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Resident Physician

1960

APRIL

Vol. 6, No. 4

JOURNAL FOR THE HOSPITAL STAFF OFFICER

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FACTS ABOUT FOREIGN GRADUATES EXAM

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page 72

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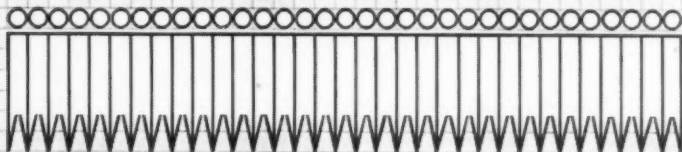
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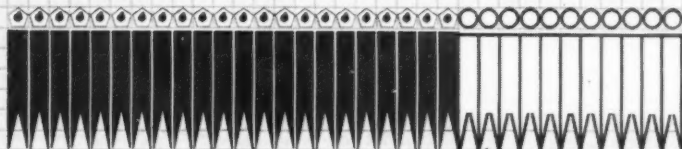
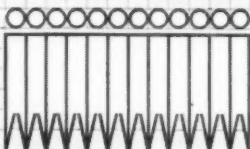
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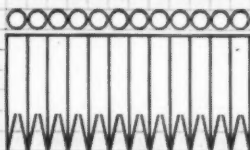
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1. Boland, E.W., and Headley, N.E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

2. Bunin, J.J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

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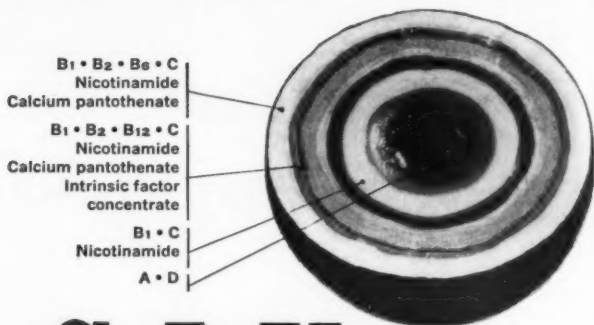
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The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.



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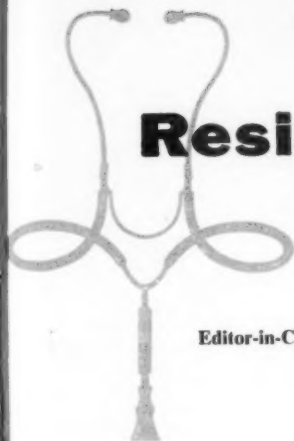
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Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

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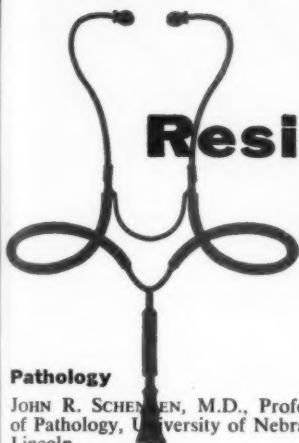
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April 1



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The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

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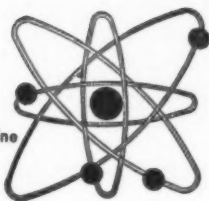
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Frigot, A.; Felix, A. J., and Mullins, S.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov. 1959).

*Experimental dosage (see dosage recommendations adjacent)

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center



*Forty-eight-year-old male. Admitted to hospital
for routine "work up." No specific complaints.*

Which is your diagnosis?

- | | |
|----------------------|--|
| 1. Normal | 3. Calcification of pelvic blood vessels |
| 2. Diabetes Mellitus | 4. Schistosomiasis of lower ureter |

(Answer on page 199)



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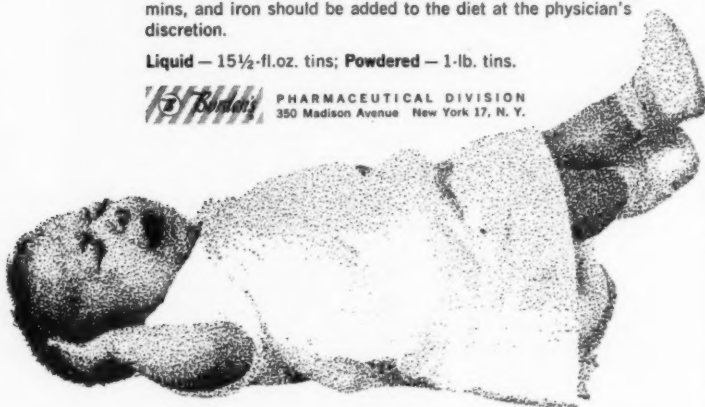
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April 1960

ACROSS

Gland with no known function

Target gland of FSH

Lacking facilities for sirloin

Occur in stomach mouth and vagina
——planus

Eponym for parathyroids

Heraldry — depicted swallowing its prey whole

Crusted ringworm

Twenty in Greece

Frogs

Common in the ovary

Nickname for 23 down

An electrolyte in the blood stream

Weird

South American plant used in gout

Arsenic, symbol

No Appreciable Disease (Abbr.)

Illium, symbol

Yttrium, symbol

God

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Short course

Intestinal Lymphatic

Prefix indicating moles

Solutions used in separation by washing

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Tell

Petticoat

A sign of infection

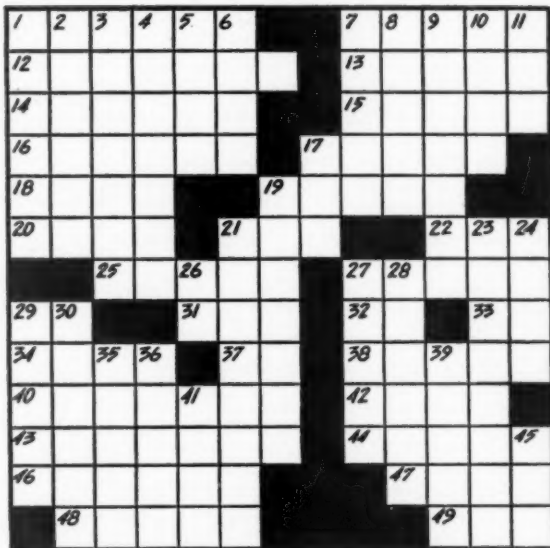
Pruritus ——

DOWN

Important exam in endocrine disease

Resident Relaxer

(Answer on page 199)



2. Result of untreated cretanism

3. To die

4. Hurry

5. Solar disc

6. Stale urine

7. Even the skin is one

8. Area subject to minor endocrine influence

9. Absence of taste

10. Grentz ——

11. Antonym of no

17. This is rarely glandular

19. Cohort of Hashimoto's

21. "Tender mother"

23. Obstetrical pituitary hormone

24. Observe

26. Useful colleague

27. Result of excess Somatotrophin

28. Contraindication of Cortisone

29. Rival of Freud

30. Form of bidding

35. Pertaining to the eye

36. Take sans permission

39. "Little grape"

41. Prefix denoting within

45. Prefix denoting surface



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Today, B-D plants operate on three continents and customers for B-D products are found around the world. As a result, you can buy B-D re-usable and sterile-disposable hypodermic equipment, fever thermometers, laboratory equipment, diagnostic instruments and elastic bandages in Auckland, New Zealand, as well as in Oakland, California. Today, too, even greater scope for service is provided by the growing family of B-D companies.

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An intimate knowledge of surgeons' needs for truly sharp cutting instruments—and the technical knowledge and skill to meet those needs—led to the development of the first detachable blade by this longtime leader in the manufacture of surgeons' knives.

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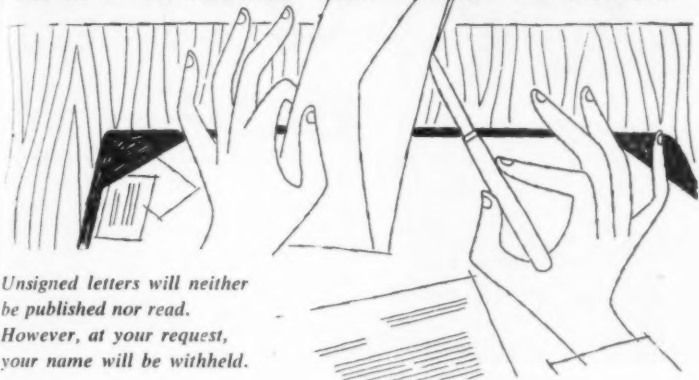
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LETTERS to the Editor



*Unsigned letters will neither
be published nor read.*

*However, at your request,
your name will be withheld.*

For the Defense

I am planning to enter a child psychiatry residency after finishing my internship. Because I have had to defend my choice to various doubters, I would appreciate reprints of some of your articles.

These would be:

1. An article which you have describing how unhappy pediatricians were as a group with their specialty.
2. An article pertinent to specialists and how satisfied they are with their specialty, specifically psychiatry.
3. Any other articles you might have from your publication relating to pediatrics, psy-

chiatry, and/or child psychiatry—their economics, shortcomings and attractions and future.

I hope this is not an imposition. I appreciate receiving your journal.

N. H. NORRELL, M.D.
San Francisco, Calif.

Down With Sweets

As an old grouch of long standing, I must register a complaint. Why does your otherwise fine journal bother with the kind of prattle that goes under the heading of "Your Wife's Talking?"

The articles in this series are so much spun sugar, despite

—Continued on page 46



a new anticonvulsant
that "oftentimes will turn
the tide" in **EPILEPSY**

ELIPTEN®

(amino-glutethimide CIBA)

Elipten is a new anticonvulsant chemically unrelated to other antiepileptic agents. Clinical trials in thousands of patients have shown that it controls most types of epilepsy and is especially effective when combined with other anticonvulsants.

Improves Control, Alertness, Learning Ability

With Elipten, more epileptic patients can be completely or adequately controlled. Elipten reduces the frequency of seizures in most types of epilepsy and is often effective in refractory cases, especially when combined with other anticonvulsants. Used adjunctively, it often permits reduced dosage of other drugs, thus minimizing their side effects; in some cases, other drugs can be eliminated.

By obviating or reducing the need for barbiturates, Elipten improves alertness and learning ability in children. It has little or no toxic effect on liver, kidney, or blood.

Forster¹ states: "Elipten... has a definite role in improving the therapy, particularly of petit mal epilepsy." He notes further that Elipten "... oftentimes will turn the tide when added to partially successful medication." Meyer² observes: "... it is useful in the control of petit mal epilepsy and is of particular benefit in those cases where petit mal and generalized convulsions are combined." Lambros³ notes complete control or marked improvement in 27 of 35 patients treated with Elipten (13 were gradually switched to Elipten alone; 14 were given other anticonvulsants adjunctively). Niswander and Karacan⁴ report that in 38 hospitalized psychotic epileptic patients given Elipten grand mal seizures were reduced 25 to 35 per cent. Carter⁵ recommends concomitant use of Elipten and diphenylhydantoin sodium "... to enhance effectiveness and reduce the dosage of both drugs."

Complete information on Elipten is available on request.

2/2794HB

SUPPLIED: Tablets, 250 mg. (white, scored); bottles of 100.

1. Forster, F. M.: *Wisconsin M. J.* 58:375 (July) 1959. 2. Meyer, J. S.: *M. Times* 87:743 (June) 1959. 3. Lambros, V. S.: *Dis. Nerv. System* 19:349 (Aug.) 1958. 4. Niswander, G. D., and Karacan, I.: *Am. J. Psychiat.* 116:260 (Sept.) 1959. 5. Carter, C. H.: *Dis. Nerv. System* 21:50 (Jan.) 1960.

CIBA
SUMMIT, NEW JERSEY

ALPEN is the oral penicillin that provides, on a fasting stomach, peak antibiotic blood levels approximately twice as high as oral potassium penicillin V... and significantly higher than I. M. penicillin G.

Some strains of staphylococci resistant to other penicillins exhibit in vitro sensitivity to potassium phenethicillin.

ALPEN has greater freedom from the G. I. sequelae (overgrowth of resistant flora) sometimes observed with broad spectrum-mycins.

ALPEN gives much higher antibiotic levels within the first hour of ingestion by the well-tolerated oral route.

WHEN TO USE ALPEN Recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci.

HOW TO USE ALPEN Depending on the severity of the infection, 125 mg. (200,000 units) or 250 mg. (400,000 units) three times daily may be used. In more severe or stubborn infections, a dosage of 500 mg. (800,000 units) t.i.d. may be employed. In beta hemolytic streptococcal infections, treatment should be continued for at least ten days.

PRECAUTIONS The usual precautions in the administration of oral penicillin should be observed. For further details see package literature. Tablets: 125 mg. and 250 mg., bottles of 25 and 100. Powder for Oral Solution (lemon-lime flavored), 1.5 Gm. bottle (125 mg. per 5 cc. teaspoonful).

this is the tablet
that gives higher peak
antibiotic blood levels
HIGHER THAN I. M. PENICILLIN G
HIGHER THAN POTASSIUM PENICILLIN V

ALPEN

ALPEN™—potassium phenethicillin

Schering

labored efforts to make them humorous. The majority of them exhibit the hysterical style that is the hallmark of the "school of bright writing," a style brought to frothy fruition in the popular women's magazines.

Bright writing, in case anyone is interested, consists of saying nothing, but doing it in a supposedly cute way. This takes strenuous effort, which leaves the author breathless in between sentences and produces a staccato quality. A generous use of *wow's* and exclamation points are used like sutures, to hold the thing together.

The aim of bright writing is not to inform, but to create a confection. And confections, like wives, are more appropriate to the kitchen.

ANDREW FUREY, M.D.
New York, N. Y.

Hypo . . . Hyper

I like RESIDENT PHYSICIAN very much especially the Mediquiz. I have been collecting "Mediquiz" for almost two years. Now I have a question. The answer for your question No. 4 of Mediquiz in June 1958 is (C), i.e. Hemolysis of erythrocytes can occur by (C) increasing plasma

osmotic pressure by dilution with a hypertonic solution. But I think the correct answer should be (B), i.e. by lowering plasma osmotic pressure by dilution with a hypotonic solution. In practice we can give hypertonic solution without fear of hemolysis of red cells, but we dare not give hypotonic solution I.V. because of danger of hemolytic reaction.

BHAKDI LIMSUNAN, M.D.
Wheeling, W. Va.

• *The correct answer is (B). The error, discovered after RP went to press, was corrected in a subsequent issue.*

Quiz Gets the Biz

The enclosed clipping from your magazine, February 1960 issue, is a further demonstration of what I have always held to be true. It took Dr. J. W. Berg a lengthy answer, a full column (reading time: 35 seconds, and I boast to be no slow reader) to explain why a certain answer was the correct "Mediquiz" answer. This means that, if that particular question were among those given at one of the I.B.M. robot-examinations, those 35 seconds should have been consumed by the examinee to make the subtle distinction of wording, between

—Continued on page 54



The
"Nervous
strain...
anxiety...
hypertension
syndrome"

...controlled
with

BUTISOL sodium

butabarbital sodium

BUTISOL relieves the tension and anxiety that contribute to hypertension—but without causing apathy or inertia. It leaves the patient capable of continuing normal activities.

BUTISOL has been shown¹ to be more effective with fewer side effects than other agents commonly used to control everyday nervousness, apprehension, tenseness and anxiety.

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TABLETS • REPEAT-ACTION TABLETS • ELIXIR • CAPSULES
McNEIL LABORATORIES, INC., Philadelphia 32, Pa.

1. Batterman, R. C.; Grossman, A. J.; Mourstoff, G. J., and Lelior, P.: A Clinical Re-evaluation of Daytime Sedatives, Scientific Exhibit, Annual A.M.A. Meeting, San Francisco, Cal., June 22-27, 1946.

—Continued from page 46

"children" and "patients." Since admittedly the questions given in your "Mediquiz" are the same used in that kind of exam, we can see very well that this wouldn't be too remote a possibility.

Therefore, I can't help but think that the examination would be more proper for an Ellery Queen-type of mind, than for the average candidate. I dare say even for the slightly and moderately - above - average, since it would take an exceptionally prepared candidate to detect and avoid the trap set up by the wording of the question. It is not a matter of one single question: Many quizzes are of this type, and many times a correct answer depends on having a Sherlock Holmes shrewdness in addition to a sound medical (general or specialized) preparation.

I do not think, either, that the basis for a correct answer, as stated by Dr. Berg (statements on Taussig, Brennenman's and Gibson's texts), legitimates the implication that the knowledge of the correct answer should be at the fingertips of all examinees. So far as I can remember, only Pico della Mirandola, Blaise Pascal and Descartes are renowned in

history for a memory enabling them to memorize and recite, from first to last word or the other way around, a whole book read just once. And how many books, please, should thus be studied to such depth and detail of words?

NAME WITHHELD

*Lahey Clinic
Boston, Mass.*

Worthy of Note

I enjoyed your article on the medical library in the current issue of *RESIDENT PHYSICIAN* very much. It is too bad the information on *Index Medicus* and the *Current List* could not have been updated to describe the present status of indexing of medical literature, but this is no criticism of the article; I know what publishers' schedules are like. The fact that this article is directed to the user, and appears in a medical rather than library journal, is worthy of note.

If you have reprints made, could you sell us ten copies? Our members frequently ask to borrow material on organizing a medical library and your articles would be helpful.

HELEN T. YAST
LIBRARIAN

Chicago, Ill.

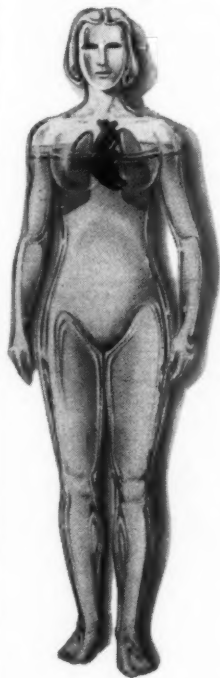
—Concluded on page 62

Resident Physician

Ford, Ralph V.: Southern Med. J. 52: 40, (Jan.) 1959

"Hydrochlorothiazide was given to patients with edema (mild to moderate) of varied etiology..."

"There were ... 5 women in the third trimester of pregnancy." In these patients the cumulative weight loss was 2 pounds after seven days of therapy and 4 pounds after twenty-one days. Gratifying relief of edema was observed in all patients.



DOSAGE: One or two 50 mg. tablets HYDRODIURIL once or twice a day, depending upon the condition and individual patient response.

SUPPLIED: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

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Additional information on HYDRODIURIL is available to the physician on request. ©1960 Merck & Co., INC.



MERCK SHARP & DOHME

Division of Merck & Co., INC. Philadelphia 1, Pa.

—Concluded from page 54

• *The reference in the first paragraph is to the suspension of the two great journal indexes and their replacement in January of this year by the single index Index Medicus. This of course was unknown to anyone at the time of the writing of my article.*

SAUL KUCHINSKY

Licensure

At one time you published in *Resident Physician* an article that

had a tabulation showing the requirements of the various states for licensure of foreign graduates. Since I will be completing my residency soon, I would like to have this information as up-to-date as possible. Do you have any way of sending me this information on all the states?

GEORGE LAMB, M.D.

Buffalo, New York

• *We will have licensure facts in the form of an article in an early issue.*



"Take me to your ledger."

Perrin H. Long, M.D.



Editor's Page

On the Quantity and Quality of Life

I. Fruitless Longevity

In the last few years, I am sure many senior physicians and surgeons (and some junior ones as well) have been troubled, as I have been, by certain of the effects of our increasing ability to prolong the life of people. The sulfonamides, the antibiotics, a better understanding of the uses of blood, machines such as artificial pace makers, and artificial kidneys, the newer breathing apparatuses, radical and improved surgical techniques, our better knowledge of nutrition, etc., all have played a role at one time or the other in saving, and hence prolonging the life of many people.

All have had the experience of walking down the hospital ward and witnessing a team composed of a resident, interns, nurses, and aides laboring with a patient who has cirrhosis, and who is in "hepatic" coma. We know that many hours and thousands of dollars may be expended in the care of this patient during the episode of coma, and that if the labors are "successful" the patient will emerge again into a painful, hopeless existence, which will eventually be climaxed by a fatal hemorrhage, or by coma and death. Next to the cirrhotic there is a patient suffering the tortures of

the damned because of the pain of tumor metastases, who has pneumonia, and who is being vigorously and successfully treated with penicillin. His suffering will be prolonged. A couple of beds away sits a thirty-five-year-old Mongolian idiot playing in a pool of his own urine and feces, saved from an early death from infection by the "miracle" drugs. In the next ward a senile old crone gibbers at us, abandoned and totally rejected by her family, who committed to modern, overcrowded, understaffed modern bedlam is waiting to recover completely from a staphylococcal bacteremia originating from a bed sore which had exposed her sacrum to the view of anyone who desired to look. At the end of the ward "Grandma" sits by her bed staring vacantly into space, and who as Glanville Williams¹ has pointed out so well has reached "an age of 'second childhood and mere oblivion' with the loss of almost all adult faculties except that of digestion. When the mind goes, purely animal health seems to improve . . . the ultimate logic of preserving the body while the mind decays would be the preservation of the physical part of human beings to eternity in some culture-solution, if such a thing were possible."

Who among us, after such sights can be proud of what we have wrought? Are we really behaving as thoughtful, ethical, humanitarians? Are we failing because, as was written in the *British Medical Journal*,² we have forgotten that "A part of the morale of the sickroom in which a patient lies dying resides surely in the general belief that the good doctor will distinguish between the prolongation of life and the unnecessary prolongation of the act of dying?"¹

What can and what should we do, and what should be our attitudes as thoughtful men and women relative to the problem of the prolongation of the act of dying?

1. Williams, G. *The Sanctity of Life and The Criminal Law*, Alfred A. Knopf, Inc., New York, 1957, pp. 349-50.

2. *Ibid.* p. 337.

It Pays to Read Current Medical Literature!

That's the theme of a new contest, the first of its kind, to begin soon in *Resident Physician*. Designed to stimulate your reading of current medical journals, the *Resident Physician* Mediquiz Contest is for resident and interns. It will be patterned after what your letters tell us is one of the most popular editorial features ever to appear in *Resident Physician*—"Mediquiz."

With questions derived by the Editor *solely from current issues of medical journals which should be in every approved hospital's medical library*, the *Resident Physician* Mediquiz Contest will offer awards exceeding \$10,000 to the winning contestants.

Coming issues of *Resident Physician* will spell out the starting date, details, rules, awards, etc.

This preliminary announcement is to alert you to the source material from which the contest questions (multiple-choice, similar to our regular monthly "Mediquiz") will be developed.

You may make notes on your reading, cross indexes, reference cards—anything you wish. (And you may ask anyone but the Editor to help you in answering the questions.)

No question will be taken from a medical journal issue published prior to April 1960.

There will be twenty questions a month for five months for a total of 100 questions. Questions will be divided between the basic sciences (about 50) and the ten major clinical sciences (about 50).

P.H.L.



Our Haphazard Residencies: A Problem of Expediency

The author takes a hard look at today's residency training and finds it wanting. The internship-residency is not primarily a graduate educational experience, he declares, because it is service-oriented, not education-oriented.

Julius H. Comroe Jr., M.D.

I do not believe there are any problems in the scientific education of specialists except those of *expediency*. If I may borrow a technic from medical investigators, this belief rests upon several assumptions which I believe to be true:

Assumption: The majority of medical students in the U. S. today (and probably in the foreseeable future as well) plan to

enter specialty practice, either officially, with the approval of a certifying board, or unofficially.

Assumption: The present four-year medical curriculum in the U. S. was planned long before this tremendous growth of specialty practice occurred. It therefore was never designed for the education of specialists and probably never will be. The four-year course is essentially a survey of the medical sciences and arts which usually has for its goal, the graduation of scientifically-trained, humanistic men and

Dr. Comroe is director of the Cardiovascular Research Institute, University of California Medical Center.

women who have been made to realize that they know only a fraction of existing medical knowledge at the time of leaving medical school; that new knowledge will accumulate at increasingly rapid rates throughout their lifetimes, and that at graduation, or very soon thereafter, they must assume personal responsibility for acquiring requisite knowledge.

Self-education

Assumption: An individual usually learns better and retains knowledge longer when he has acquired it entirely or largely by his own processes.

Assumption: Self-education, though vital, is time consuming; it may take ten to a thousand times as long to acquire a new bit of knowledge by self-education or research as it does to relay it, once acquired, to a student or fellow learner. A medical

lifetime is too short to obtain every bit of knowledge (even every essential bit of knowledge) by this tedious process. Consequently, much knowledge must be acquired in a less-than-ideal way: i.e., the teacher communicates to the learner in a very short period of time, by a variety of techniques, the knowledge that he has acquired over many years or decades.

When the communication is verbal and directed to a group of learners at regular recurring intervals, we call this a "course." Courses are an acceptable and respectable part of the educational experience in secondary schools, colleges, medical schools and beyond the internship-residency program; they are by and large not a respectable part of the hospital specialist training program. This brings me to my next assumption, namely that the "approved hospitals" are not and never have been part of our total structure of medical education.

Assumption: The internship and residency, with possibly a few exceptions unknown to me, have never been designed wholly or in large part as an experience in graduate medical education, in the way that the medical school course has been designed for undergraduate medical education.

This paper was presented at the second World Conference on Medical Education, August 29-September 4, 1959. Titled "Place of Applied Basic Science in Advanced Training with Special Emphasis on Formal Courses in Applied Basic Sciences," it will be published in the Proceedings of the Conference. Advance publication in RESIDENT PHYSICIAN is through the courtesy of the World Medical Association.

Hospital training began largely as an apprenticeship in which the newly graduated physician, steeped in theory, now learned the trade aspects of his profession.

True, in past years some hospitals provided certain educational opportunities, because they so wished. True, today all hospitals must provide an educational program to be accredited for specialty training, even though some of this is purely a program "on paper." However, because the service of the intern and resident to the hospital comes first and the educational obligation of the hospital to the intern-resident comes second, the internship-residency is not primarily a graduate educational experience. It is service-oriented and not education-oriented.

Essential

Assumption: Continued education, both in the art and science of a specialty, is essential in the residency period because the medical school never intended to teach its students to be specialists. For example, radiation physics is not taught in detail in medical school because only a few of each hundred undergraduate students will become radiologists and require this knowledge; the

physiology, pharmacology and biochemistry of the eye are mentioned only briefly in the medical course because only one or two of the class will become ophthalmologists. Example after example can be given to prove the point that medical education is definitely unfinished at the end of the fourth year.

Must continue

I began by saying that there are no problems in the scientific education of specialists except those of expediency. If you grant that my assumptions are reasonably correct, then you must agree that the residency is the time when much more must be learned than can be learned by individual self-education—in short, formal medical education must continue into the residency. If we are perfectly honest and avoid rationalization, such education does not now exist except in a haphazard sort of way. Why doesn't it? It is simply a matter of expediency.

- There is *no money* for graduate medical education. The intern-resident is already in debt and cannot pay further tuition.
- There is *no time* for graduate medical education. The care of the patient comes first. It may be the thousandth intravenous infusion that the resident must start

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although his effective learning process was complete after the thirty-second; nevertheless he must carry through to number one thousand. Might not a cardiologist's time be better spent learning the basic mechanisms of cardiovascular regulation, or the urologist's time be spent better learning detailed renal physiology? However the problem is: Who will give the infusions if the residency becomes a period designed for more learning and less for doing simple mechanical tasks over and over again?

The resident must do many mechanical tasks but not beyond the point of educational gain. Ideally, a residency should be a planned educational experience which continues the previous medical education in such a way that both the art and science of the specialty are learned without big gaps in either aspect. It is not *expedient* to do this at present. However I am convinced that a five year surgical residency, for example, would shrink to four or three if the residency were a planned learning experience stripped of everything which contributes to running an efficient

hospital but not to education.

- There is no basic science faculty for 1200 approved hospitals in the U.S.A. Actually there are not enough physiologists, pharmacologists, biochemists, microbiologists, pathologists and anatomists to teach the basic medical science aspects of specialty practice even in the teaching hospitals associated with our medical schools. The faculties in the basic medical sciences in medical schools are kept more than busy teaching medical, dental, nursing, veterinary, and pharmacy students and cannot be imposed on further.

Differentiate

I have no solution to these problems, but I do believe that the first step is to differentiate clearly between a system which exists because it is *expedient* and an *ideal* graduate educational system. If we cannot do better than compromise, let us at least say that we are compromising. To rationalize the present system as ideal is to delay the ultimate incorporation of the residency into an overall plan of medical education.

Fifty-Sixth Annual Congress on Medical Education and Licensure

On the morning of February 6th, your Editor was in Chicago to attend the Fifty-Sixth Annual Congress on Medical Education and Licensure sponsored by the American Medical Association, the Advisory Board for Medical Specialties, and the Federation of State Medical Boards.

This particular Congress had a rather intriguing looking program. Sunday morning was to be devoted to the subject of "The Role of Patient Care in Basic Medical Education," Sunday afternoon to "The Role of Patient Care on Education Beyond Medical School," Monday morning to "Medicine as a University Study," and Monday afternoon to "Looking Forward Towards Tomorrow's Medical Student." On Tuesday morning the problem of "International Medical Education" was discussed.

The meeting was attended primarily by deans, medical administrators, and a fairly sizable number of directors of education from hospitals in this country. Interestingly enough, as always seems to be the case in meetings such as this one,

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very few active teachers of medicine were in evidence, unless they were speakers on the program. This may be the reason why so many meetings devoted to Medical Education (with a big M and a big E) miss out so badly.

Right here, I would like to speak out on a current phenomenon, namely that those who do relatively little or no teaching, either of undergraduates or graduates, often are most vocal on medical education. I am referring to the deans and administrators. As I pointed out in discussing the Second World Conference on Medical Education, the relative narrowness and sterility of thought in respect to new educational (not pedagogical) concepts, which mark so many of these conferences on medical education may stem from the fact that the speakers are inactive in teaching. Also, it may be that those of our deans and administrators who are non-medical, lack the broad comprehension which is needed to understand the total sweep of medical education in its undergraduate, graduate, and postgraduate phases.

P. H. L.

SPECIAL REPORT

FROM THE FIFTY-SIXTH CONGRESS ON
MEDICAL EDUCATION AND LICENSURE

The Role of Patient Care in

This part of the program was opened by Dr. Samuel Martin of the University of Florida Medical School. He discussed "Clinical Education as a Continuum." He pointed out that in 1892, Sir William Osler, in a talk given to the medical students of the University of Minnesota, stated that the good doctor looks for and formulates the problems of disease, then he develops a hypothesis or theory about the disease, which he tests; then he re-orientes himself on the basis of the results of his testing. It is the job of educators to develop built-in habits of doing this. The stimulus should be the patient and his illness. Dr. Martin stated that it was not necessary that all patients have "interesting" diseases because the student or physician can profit from the study of any sick person. He discussed the possibility of telescoping

the intern year back into the medical school curriculum. He thought that there should be training in practice objectives, and he stressed the point that the educational program must represent teamwork between the doctor, the student, and the patient.

Responsibility, judgment

The next paper, presented by Dr. William Holden of Western Reserve University School of Medicine, "Developing the Young Physician's Responsibility and Judgment in Patient Care," reflected the author's surgical training. To develop most easily the intellect of interns and residents, an educational environment which will provide increasing responsibility for the care of sick people is necessary, according to Dr. Holden. Also, the motivation of the intern or resident must be cor-

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Education Beyond Medical School

Perrin H. Long, M.D.

rect, and the motivation must be kept at a high level throughout his training period.

As far as general surgeons are concerned, they should pass through all fields of surgery in the course of their training. The author thought that in certain respects training should be differentiated from education, the former concerning itself with the development of ability, i. e., technical skills.

To make training top-flight, an environment must be provided by the members of the teaching staff which is optimal for the development of a sense of responsibility and of clinical judgment. In such an environment, the spirit of inquiry should be easy to maintain. Also, it is extremely important that the residents have time for thought and the preparation of their work.

A program cannot be left to chance, but must be organized, and have someone on the staff who will spark and guide it. In such a program all must participate, the resident must teach his junior, who in turn must spend much time in the instruction of the intern, who in his turn is closest to and hence must be the mentor of the student.

Provocative

The third paper, delivered by Dr. James Bordley, III, director of Mary Imogene Bassett Hospital in Cooperstown, New York, *was without question the most provocative and thought inspiring in the three-day program.* Dr. Bordley put into well expressed words the thoughts of most thinking senior physicians and surgeons relative to certain problems which today are in-

creasingly affecting patient care. It is to be hoped that all readers of **RESIDENT PHYSICIAN** will go through Dr. Bordley's paper on "The Effect of House Staff Training Programs on Patient Care," when it appears in the **JAMA**.

Briefly, he states that as the personalities of house officers and patients vary, and as patients have very little background in rating the ability of doctors, it sometimes astounds chiefs of service to find that interns, whom they consider to be of doubtful ability, are praised very highly by patients. It is a problem therefore to decide what weight should be given to patients' estimates of their doctors.

There is, Dr. Bordley pointed out, a certain incompatibility between patient care and house staff training programs. At times patients are not enthusiastic about being fitted into the house staff training programs. As the patient is generally paying for his care, he must know what he is paying for and this requires explanation. A knowledge of the patient's objections is valuable in making these explanations. Here are some of them:

- Patients in a hospital which has a complete house staff training program, or is a teaching hospital, object to the duplication of

questioning and examining. It must be explained to them that such duplications are inevitable and often are of value because data is turned up by one doctor which had not been noted by the others.

- Some patients feel that ward rounds are upsetting. This reaction can be minimized by conducting rounds carefully, by watching what is said, and by reassuring the patient by action and word of mouth.

- Other patients complain of the impersonal attitude of the house staff. It is up to whoever is in charge to do everything he can to lessen this. Of course, as interest is often a part of personality, this may be difficult to cope with.

- One comment which may seem rather startling is that modern physicians place too much accent on longevity, and that they are more interested in the quantity of life they give patients, than they are in the quality of that life. There are times, as the author says, when it is necessary "to make the house staff realize that they are not shirking their responsibilities if some of the time and energy which they now feel compelled to spend in the cause of fruitless longevity, were to be devoted to the promotion

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of factors which make it possible for their doomed patients to live in peace and comfort, and for their surviving patients to live more abundantly."

● At times patients also complain that too much responsibility is shared with the house staff. Often the patients confuse authority with responsibility, and when they do, the conflict must always be resolved in favor of the patient. Responsibility must be shared because, only by doing so can maturity of thought and action be developed in the house staff. At times patients under-rate house staff and refuse to do what they are told. This can generally be coped with by a bit of talking by a senior physician about the importance of the house staff in modern medical care. The house staff member must be built up. Overrating the house staff may also constitute a problem with certain patients who get attached to their interns. This should be watched for carefully, especially in community hospitals, because it may lead to something definitely undesirable, namely, the undermining of the position of the family physician. As Dr. Bordley puts it, "the sheer size of the medical team resulting from the presence of the house staff is baffling to some pa-

tients." They may feel that "too many cooks will spoil the broth." This can be prevented by having a booklet given to each patient which among other things describes the medical staff and contains a story of the duties of the house staff in relation to newly admitted patients.

Contributions

Now on the other side of the coin, the author has enumerated the contributions made by the house staff to the total care of the patient.

Firstly, the integrated team approach produces a thoroughness which cuts down the chance that something will be missed. *Secondly*, the patient receives the benefit of highly technical skills from the house officer. Certainly, most will agree that the house staff member is more adept at venapuncture or lumbar puncture than the senior attending. *Thirdly*, when a hospital has a house staff, a physician is always quickly available in times of emergency. *Fourthly*, the presence of a house staff keeps the attendings on their toes scientifically speaking. *And last but not least*, each year members of "the house staff . . . transmit to the hospital community fresh attitudes and factual knowledge

which they have absorbed in the scientific environment of the university from which they had just come."

In concluding his discussion of the house staff and its effect on patient care, Dr. Bordley draws attention to the fact that overall training of the house staff and the care of the patients has suffered, because in this day and age when more than fifty percent of American-born house staff members are married, the problem of time on and time off, i. e., "the fixed schedule" plays too great a role in the thinking of the medical student, intern, and resident. He feels that it may well undermine the sense of responsibility which a physician should feel towards his patients, and produce a "mass movement of young doctors towards careers which offer a 40-hour week."

Ambulant patient

The fourth paper of the afternoon was on the subject of "The Ambulant Patient's Contribution to the Education of Interns and Residents," and was presented by Dr. William D. Loeser of the Youngstown (Ohio) Hospital Association. His talk was based on the role of outpatient departmental work for the house staff in nonteaching hospitals. As he

pointed out, one has an outpatient department to meet the needs of indigent and medically indigent people in the community, and to provide adequate after care and follow-ups for such patients. Participation in such a program provides valuable training for the house officer because it provides an opportunity for follow-up, and even more important, a chance for the house officer to get to know his patient as a person.

Continuation

The final presentation of the session was made by Dr. George Robertson of Thayer Hospital in Waterville, Maine, on the subject of "Continuation Education in Hospitals Without House Officers." As is only too well known, physicians are liable to lose their habits of study after they finish their graduate training because 1) it takes time to build a practice, 2) it takes time to build up their families, and 3) they can't afford to go away in their early years in practice.

Despite this, everyone recognizes that a continuing educational program is of major importance in every doctor's life, if he is to provide proper medical care for his patients.

Dr. Robertson outlined the

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"do it yourself" program which had been so successful in Thayer Hospital. In essence it consisted of obligatory attendance at weekly, one hour staff meetings, in which various staff members presented the case reports of interesting and instructive, or puzzling patients. This was supplemented in time by a tumor

board, and still later by guest doctors to whom patients were presented. One of the unexpected results of the conferences and the discussions which were engendered by them was that the staff became much more cohesive and utilized each others skills to a much greater degree than had been done previously.

Next month Dr. Long continues his report on the Annual Congress on Medical Education and Licensure with "The Role of Patient Care in Basic Medical Education."

NEWS ROUNDS

OB Exam Deadline

Applications Open—Applications for certification by the American Board of Obstetrics and Gynecology, new and reopened, Part I and requests for re-examination in Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is August 1, 1960. No applications will be accepted after that date.

Your Questions About ECFMG Answered

Dean F. Smiley, M.D., Executive Director
Educational Council for Foreign Medical Graduates

Here are answers to questions sent in by Resident Physician readers concerning the American Medical Qualification Examination and the certification of foreign medical graduates by ECFMG.

Q

"I am a native American who received my medical training and M.D. degree at an approved Swiss University, and studied at this University on the implied recommendation of the AMA's Council on Medical Education. Since my graduation, I very successfully completed an approved internship and have been licensed to practice medicine in two states by separate examinations.

Furthermore, I am now a member of my county and state medical societies and an associate member of the AMA.

If I should apply for residency training after January 1, 1960, would ECFMG certification be required, even after two American licensing bodies have examined me and my credentials and found "us" worthy and well-qualified?"

A

No, ECFMG certification would not be required. Foreign medical graduates who have obtained permanent and unrestricted licensure in one of our states or territories are considered certified by the Council on Medi-

cal Education and Hospitals of the AMA, just as are ECFMG certificate holders.

Q

"Will the foreign-trained (but long since U. S. licensed) physicians and surgeons who are now teaching in American medical schools be put to the trouble (and discriminatory practice) of taking the ECFMG examination?"

A

No, not if they are licensed in the state in which they are teaching. Yes, if their state of residence does not recognize their license in another state, requires the passing of their state licensing examination, and requires ECFMG certification preliminary to admission to their licensing examination.

Q

"Between 1950 and the present, the AMA Council on Medical Education and Hospitals has maintained a list of approved foreign medical schools, the graduates of which are supposed to be treated equally with the graduates of bona fide American medical schools. On the basis of this list, many Americans studied at one of the approved medical schools whose courses are longer and more expensive than comparable courses at some of the so-called non-approved schools. To be the graduate of an AMA approved medical school is, no doubt, a form of equity. Yet Dr. Smiley thinks nothing of robbing graduates of approved foreign schools of the value of their diplomas. Ex post facto laws are prohibited by our Constitution and our mores, and nothing could be more un-American and more unethical than changing the rules of the game after the game is over. Since the ECFMG is an extra-legal agency, it apparently doesn't have to bother about the niceties of the law or ethics?"

A

Between 1950 and 1957 the Council on Medical Education and Hospitals of the AMA and the Association of American Medical Colleges maintained a list of approximately 50 foreign medical schools, whose graduates were recommended for consideration on the same basis as graduates of U. S. medical schools.

When the ECFMG was organized October 1, 1957 the Council and the A.A.M.C. ceased distributing the list, and in 1958 announced that as of January 1, 1960, the list would go out of existence and would not be republished. It had become evident that such a fragmentary listing of foreign schools by U. S. medical educational authorities, based on inadequate visitation and evaluation, was unsound from the medical educational point of view and unwise from the point of view of international relations.

The ECFMG admits to its American Medical Qualification Examination any graduate of a recognized school of medicine who presents evidence of 18 years of formal education, at least four of which has been in a recognized school of medicine. All 533 medical schools abroad as listed in 1957 edition of the World Health Organization's World Directory of Medical Schools are considered as recognized.

Instead of basing judgment of a foreign medical graduate's fitness to take up training as an intern or resident in a U. S. hospital solely upon his school of graduation, the ECFMG bases its judgment primarily upon the individual's ability to demonstrate his knowledge of medicine and his command of English by passing its American Medical Qualification Examination and ECFMG English Test. He must, however, be a bona fide medical graduate in order to be admitted to the examination.

American nationals who chose to attend a foreign medical school because it was on the 1950-1957 Council and A.A.M.C. list have not had any of their rights

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abridged by the new plan. They obtained, presumably, a good medical education which will undoubtedly enable them to acquit themselves creditably on the ECFMG's American Medical Qualification Examination. The ECFMG certification plan is, as everyone will agree, much more fair than was the older plan in the opportunities it offers to graduates of all recognized schools of medicine world round.

Q

"How is it, then, that an American citizen and foreign graduate who passes the ECFMG's American Medical Qualification Examination and obtains a medical license is denied reciprocity?"

A

Each state in this country lays the responsibility for issuing licenses to practice medicine in that state upon its own Board of Medical Examiners, or some similar state-constituted authority. With fifty-five such boards, each having its own regulations based upon local attitudes, needs and problems, it is not surprising that great variation has occurred and that a foreign medical graduate ruled fit to practice medicine in one state may not even be admissible to the licensing examination in an adjacent state.

Passing of the ECFMG's American Medical Qualification Examination will be of great assistance to a foreign medical graduate in gaining admission to licensing examination in 35 states, the District of Columbia, Guam and the Virgin Islands. No foreign medical graduates are admitted to licensing examination in Arkansas, Idaho, Louisiana, Nevada, Oklahoma, South Carolina, Utah, Wyoming, the Canal Zone, or Puerto Rico, according to their present laws. Their present regulations permit giving no weight to ECFMG certification in California, Colorado, Illinois, Massachusetts, New Jersey, New York and Hawaii.

The whole matter of reciprocity or endorsement of medical licenses from one state to another, both for U. S. and foreign medical graduates, is under continuous study by the Federation of State Medical Boards of the U. S. Progress is being made but it is not as rapid as many might wish it to be.

Q

"What is the advantage of taking the ECFMG examination for a U. S. citizen or a U. S. citizen-to-be who has completed U. S. internship and residency?"

A

Being ECFMG certified will help such a foreign medical graduate gain admission to licensing examination in 38 states or territories. It will also be helpful to him in gaining admission to the certifying examination of most of the specialty boards.

Q

"Is there any hope that the ECFMG-qualified foreign medical graduate, who has obtained a medical license in one of the States, will be given reciprocity in another State, just by paying the reciprocity fees, like any American graduate?"

A

Yes, such arrangements are not infrequently worked out today and they will undoubtedly be more common in the future. It should be pointed out, though, that neither the principle of reciprocity nor of endorsement of license between states is universally accepted in regard to U. S. medical graduates. Until this principle is universally accepted for graduates of U. S. medical schools, it is somewhat unrealistic to expect it for foreign medical graduates.

Q

"Is there any hope that the ECFMG examination, will really qualify the foreign graduate as equal to an American graduate, in the eyes of the various national and state medical authorities?"

A

Yes. The ECFMG is qualifying more than eight out of ten candidates applying from some foreign medical schools with first class teaching programs, but it is qualifying less than two out of ten candidates applying from some other foreign medical schools with inferior teaching programs. Deans of foreign schools are receiving, upon request to the ECFMG, the accomplishment records of their alumni along with the accomplishment record on all candidates, world-wide.

Q

"Was the ECFMG formed just to represent one more obstacle in the way of the U. S. citizen, partly U. S. trained, foreign medical graduate?"

A

No. The ECFMG was formed (1) to disseminate information to foreign medical graduates contemplating graduate medical work in U. S. hospitals, and (2) to enable foreign medical graduates while still in their home country to qualify themselves both as to command of English and knowledge of medicine for successfully assuming a place as an intern or resident in a U. S. hospital.

Q

"The evaluation of foreign medical schools by U. S. medical educational authorities only lasted a few years. Is the ECFMG certification program going to also be just a temporary effort?"

A

Time alone can answer that question. It has the backing of the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and the Federation of State Medical Boards of the U. S.

Q

"What has been the record of the ECFMG to date?"

A

The following table shows the results thus far.

AMERICAN MEDICAL QUALIFICATION EXAMINATION

DATE	EXAMINED	QUALIFIED *
March 1958	298	68%
September 1958	844	76.3
February 1959	1,772	68.8
September 1959	2,351	68.8
March 1960	(More than 7,000 have applied)	

* For either permanent or temporary (2-year) certificate.

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**NORTH
CAROLINA
MEMORIAL
HOSPITAL**

Coagulation Problem Conference

This conference was edited from the proceedings of one of the departmental and interdepartmental conferences held weekly at NCMH. Dr. J. D. Geratz acted as editor. Participants in this conference were Dr. K. M. Brinkhous (moderator), Drs. John B. Graham, N. F. Rodman, and J. D. Geratz (pathology), Drs. R. A. Ross and L. M. Talbert (obstetrics), Dr. John H. Ferguson (physiology) and Dr. Harold R. Roberts (medicine).

Clotting Defects with Hydatidiform Mole

DR. K. M. BRINKHOUS: We have a rather unusual case of a coagulation defect occurring as a complication of a hydatid mole for consideration today. Dr. Geratz will first present the clinical and laboratory data, and then we will proceed with a general discussion of many of the problems encountered in this interesting case.

DR. J. D. GERATZ: This was

the fourth pregnancy for this 28-year-old woman who had had two previous term deliveries and one abortion. The last menstrual period was 12 weeks prior to this admission. She was well until approximately two weeks prior to admission when she noticed the onset of slight but persistent vaginal bleeding and also began to experience increasing nausea accompanied by vomiting.

On admission she was rather pale and weak and appeared moderately dehydrated. There was a subsiding generalized urticaria, the cause of the rash being an allergic reaction to phenobarbital. The temperature was 98°F, blood pressure 130/70 mm. Hg., pulse rate 86/min. and respiratory rate 16/min.

Examination

The uterus was considerably larger than would be expected in a pregnancy of 12 weeks duration, the fundus being located at the level of the umbilicus. Fetal parts could not be felt, nor could fetal heart sounds be heard. The cervix was closed. X-ray examination did not show any fetal bony structures. The clinical impression was that the patient probably had a hydatid mole.

The hematocrit was 35, and white blood count 8,600 with a normal differential count. The direct bilirubin was 1.1 mg. %, total bilirubin 1.9 mg. %. The electrolytes were unremarkable. There was 2+ proteinuria and 4+ acetonuria. The urine sediment contained 20-30 red cells and 4-6 white cells/HPF.

The patient was treated with bed rest, i.v. fluids, Dramamine and Compazine. There was some decrease in nausea and vomiting,

but there was no improvement in the general condition of the patient.

Two days after admission the hematocrit had dropped by 10 points to 25, a decrease not accounted for by the external blood loss. It was decided to remove the suspected mole as soon as possible. The patient received 3 units of fresh blood, and on the fourth day after admission a hysterotomy with removal of a large hydatid mole was performed.

The patient withstood the operation well and there were no postoperative complications. Postoperative medications included tetracycline, 250 mg 4 times daily.

Liver function studies done on the third postoperative day gave some evidence of liver damage. There was a BSP retention of 24%, and the cephalin flocculation test was 1+ after 24 hours and 2+ after 48 hours. By the fifth postoperative day, however, liver function had become nearly normal, with a BSP retention of only 7% and a negative cephalin flocculation test. The total bilirubin at that time was 1.1 mg %.

Repeated examinations of the urine showed disappearance of protein, but persistence of small numbers of red cells. Free hemo-

CLOTTING DATA

DAYS AFTER ADMISSION	3	4 a.m.	4 p.m.	5	6	7	8	9
Prothrombin Time (sec.) (control—12.7 sec.)	21	16	15	17	21	22	14	12
Partial Thromboplastin Time (sec.) (control—75 sec.)	166	113	131	108	175	151	79	74
PERCENT OF CONTROL:								
Fibrinogen	85	40	36					
AHF	38	89	74	87	140	122	122	130
PTC	43	43	36	70	77	87	85	107
Stuart	13	16	20	15	12	8	47	
Factor VII	16	38	32	11	13	6	40	
Prothrombin	15	11	13	11	12	10	64	93
TRANSFUSION WHOLE BLOOD	2 units		1 unit					
VITAMIN K					10 mg. 10 mg.			

globin was not demonstrated in the urine. PSP excretion was diminished, amounting to only 35% in 2 hours.

Coagulation studies

On the third day after admission (one day prior to the operation) comprehensive coagulation studies were done on the patient's plasma and revealed deficiency of nearly all clotting factors examined. The prothrombin time was 21 sec. (control 12.7 sec.), and the partial thromboplastin time was 166 sec. (control 75 sec.). The levels of antihemophilic factor (AHF), plasma thromboplastin component (PTC), factor VII, Stuart factor, and pro-

thrombin were markedly reduced. Only the fibrinogen level was near normal, initially. The platelet count was 75,000.

Immediately after transfusion of 3 units of blood, on the day of the operation, the levels of AHF and factor VII had about doubled. The levels of Stuart factor, PTC and prothrombin, however, remained essentially unchanged, while the fibrinogen level even dropped to 36% of the control.

In the three days following the operation the AHF and PTC levels spontaneously rose to near normal values. Factor VII levels, on the other hand, decreased to less than the pretransfusion val-

ues, and Stuart factor and prothrombin also showed a further decline. At this point the patient was given 10 mg of vitamin K and within 24 hours a striking increase in these factors had occurred.

After an additional 10 mg of vitamin K, on the next day, the prothrombin level was normal and so were the prothrombin time and the partial thromboplastin time.

Course after discharge

The patient was discharged on the 12th hospital day.

She was readmitted for a D & C three weeks later. The pathologic diagnosis on the uterine scrapings was syncytial endometritis. The hematocrit was normal, and the urine was unremarkable. Several pregnancy tests done at monthly intervals were negative.

DR. BRINKHOUS: There are many problems brought up by this case, and I will call first upon Dr. Ross for any comments he would care to make.

DR. R. A. ROSS: The clinical diagnosis of hydatid mole was rather easily made from the size and shape of the uterus, the absence of fetal heart sounds and the failure to demonstrate fetal bones on x-ray examination. We

did not study the level of chorionic gonadotrophin because the determination would not have helped us much in our diagnosis. The level is high in hydatid moles, but will also be inordinately high in normal pregnancies around the 90th day of gestation. The incidence of toxemia of pregnancy is noteworthy in hydatidiform mole.

Hydatid mole is a rather rare tumor in this country, probably one case in every two thousand pregnancies; but it is a relatively frequent complication in Indonesia and the Philippines and this may suggest some racial predisposition. In our population, however, the white and colored races appear equally affected. The reason why some women develop hydatid mole is still unknown, though some investigators have considered the possibility of a hypersensitivity reaction, similar to the reaction causing erythroblastosis fetalis.

Usually, it is our method to deliver these patients vaginally. But here we had to resort to a hysterotomy because the patient was going downhill and the cervix was still closed. In the course of our preoperative studies we were concerned over her clotting mechanism, and the advance information on her clotting defects

was of great help to us in handling the situation.

Laboratory

DR. BRINKHOUS: We might look at the laboratory findings and see how we can explain the disturbance in her clotting mechanism. These studies were all done in your laboratory, Dr. Graham, and you may want to give your opinion regarding the results.

DR. J. B. GRAHAM: This was the first case of this type that I have had the opportunity to study, and there were certainly many interesting and surprising findings. The prolonged prothrombin and partial thromboplastin times suggested that this patient was either severely deficient in those factors that affect both tests, such as factor V or Stuart factor, or that there was a more complex situation.* The latter proved to be true as shown by the assays for the individual clotting factors which were all clearly abnormal. Although the initial fibrinogen level was nearly that of the control, I suspect this represents a low value for this patient, because in pregnancy the fibrinogen level is usually elevated. The mild persistent hematuria was not surprising, because hematuria is often the first evidence of a

hemorrhagic crisis, e.g., in hemophilia and during anticoagulant therapy.

It was interesting to follow the patient's response to transfusion and the administrations of vitamin K. After transfusion the anti-hemophilic factor came rather quickly back to normal, followed at a somewhat slower rate by the plasma thromboplastin component. On the other hand, the levels of Stuart factor, factor VII, and prothrombin — substances normally produced in the liver — were not influenced by the transfusions of whole blood, but responded to the administration of vitamin K. This is analogous to our experience with overdicumarolized patients. Transfusions seldom affect these factors significantly and it is always necessary to give vitamin K. One puzzler is why the PTC level returned to the normal range before vitamin K was given; PTC is probably also produced by the

* Prolongation of the prothrombin time will result from a deficiency of one or more of the following factors: prothrombin, factor V, factor VII, Stuart factor and possibly PTA and Hageman factor.

Prolongation of the partial thromboplastin time will result from a deficiency of one or more of the following factors: AHF, PTC, factor V, Stuart factor, Hageman factor, PTA, prothrombin.

liver and its formation is dependent on the presence of vitamin K.

Reduced intake

DR. GERATZ: As shown by the cephalin flocculation test and the BSP retention as well as by our specific assays the liver function was certainly impaired, and several factors may have contributed to this. The patient had had little food intake for about two weeks preceding her admission and probably glycogen and other stores in the liver were rather depleted. The dietary intake of vitamin K was presumably reduced. We can assume an influence of the tetracycline on the intestinal flora, and therefore the supply of vitamin K from bacterial sources was probably decreased also.

DR. BRINKHOUS: From what has been said several mechanisms might have been operative in this case to affect liver function: a disturbance of carbohydrate metabolism, some possible "toxic" damage, and lack of vitamin K. I want to stress one point, however. Administration of vitamin K will correct an existing deficiency of the vitamin, but it will not improve liver function impaired for other reasons. The dramatic response of this patient

to vitamin K can be taken as evidence that vitamin K deficiency was the main problem at the time of its administration and that the other pathogenetic mechanisms were no longer of great importance.

It should be emphasized also that the body is not able to store large amounts of vitamin K. For the supply of the vitamin the body normally has to depend on diet and probably bacterial flora of the gut. In our case here, in face of a reduced supply of the vitamin there was probably an increased need for vitamin K, for the liver had to replenish factors lost with bleeding and also presumably with intravascular clotting.

Impairment

This brings up another aspect of this case. It is a widely held concept today that some of the complications of pregnancy, such as toxemia, abruptio placentae, dead fetus, and rarely hydatid mole may be accompanied by thromboplastinemia, the thromboplastic material probably originating in necrotic tissue in the product of conception. The release of such material into the maternal blood stream may induce clotting and will lead to the depletion of factors such as AHF

and also of platelets, while other factors such as Stuart factor, PTC and factor VII would be expected to remain unchanged. I believe in our case one pathogenetic mechanism was impaired liver function, both through cellular injury and hypovitaminosis. Another mechanism appears to have been intravascular clotting. Dr. Roberts, you have studied thromboplastinemic states with intravascular clotting. Would you like to remark on your experience as to the effects of thromboplastinemia in experimental animals?

Experiments

DR. H. R. ROBERTS: The purpose of our studies, which Dr. Penick, myself and others undertook, was to find the cause of some of the hemorrhagic complications of pregnancy, of carcinoma of the lungs and of operations, and to see whether they could be attributed to thromboplastinemia or fibrinolysis. We found that injection of small amounts of thromboplastin into dogs would decrease the levels of AHF and factor V and the number of platelets but with these small amounts, fibrinogen was not significantly altered. With larger quantities we could also reduce the fibrinogen level to near zero.

Fibrinogen level

DR. J. H. FERGUSON: Since 1901, cases of so-called uteroplacental apoplexy with a hemophilia-like state have been observed, and since then physicians have become more and more aware of the disorders of hemostasis in cases with premature separation of the placenta, eclampsia, amniotic fluid embolism and occasionally in hydatid mole. The common factor in these cases is usually a lowered fibrinogen level. Some show fibrinolytic enzyme activity and multiple coagulation defects.

In the present case we have to approach the explanation in three ways: 1) intravascular appearance of thromboplastin, 2) impairment of liver function, and 3) possibility of activation of fibrinolysin, keeping the fact in mind that tissue fibrinolysokinases are especially rich in the uterine tissue.

DR. ROSS: In our practice hypofibrinogenemia is most commonly seen in uterine apoplexy and in patients with a retained dead fetus, the latter sometimes in the presence of Rh sensitization. I do not believe that uncomplicated amniotic fluid embolism will cause hypofibrinogenemia. We injected amniotic fluid into dogs and noticed no ill ef-

EFFECTS OF VARIOUS PATHOGENETIC MECHANISMS ON CLOTTING

	AHF	PTC	FACTOR V	FACTOR VII	PROTHROMBIN	STUART FACTOR
Intravascular clotting	D	?U	D	U	D	?
Fibrinolysis	D	?	D	?	D	?D
Vit. K. Deficiency	U	D	U	D	D	D
Liver Damage	?D	D	?D	D	D	D
	D—Decreased		U—Unchanged			

fects. In cases where the amniotic fluid contains meconium, however, shock will be an important factor and often prove fatal.

I do not know what part of a mole could be responsible for the thromboplastinemia; the hydatid fluid certainly does not seem to have anything remarkable about it. Dr. Roberts, in your experiments did you find any intravascular fibrin deposits after the injection of thromboplastin?

Fibrin deposits

DR. ROBERTS: We could not demonstrate any fibrin deposits in those animals that came to autopsy. Other investigators encountered the same fact, and it has been suggested that the clotting process itself may activate the fibrinolytic enzyme system which then removes the fibrin. However, we were unable to

show such an activation consistently in our experiments. May I also say that there seems to be some activation of fibrinolysin in conditions of acute stress, and that fibrinolysin will also attack AHF.

DR. GERATZ: As to the occurrence of fibrin deposits in fatal cases with hydatid mole, I would like to mention the report of at least one such case in the literature. At autopsy there were found widely distributed intravascular deposits, the fibrin strands characteristically arranged in the flow lines of the blood.

DR. FERGUSON: We studied a woman with abruptio placentae who showed the presence of active fibrinolysin and depressed levels not only of fibrinogen but also of factor V. The low levels of fibrinogen and factor V were explained by the proteolytic action of fibrinolysin on both these substrates. AHF levels and the

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ON CLOTTING FACTORS

STUART FACTOR	FIBRINOGEN	PLATELETS
?	D	D
?D	D	U
D	U	U
D	D	?

platelet count were normal in this case. I would like to add here that episodes of fibrinolysis or intravascular clotting and the resulting changes in the clotting factors are often extremely short-lived. If either of these events be followed by continued hemorrhaging, however, the factors, already lowered, may be removed faster than the damaged organs, especially the liver, can build them up. Such a mechanism may account in part for the fact that this patient's deficiencies were seen over a period of several days.

DR. N. F. RODMAN: I wonder also where fibrinolysis may not have played a role in the patient, though the laboratory data do not include any remarks on clot lysis. Fibrinolytic activation may result in multiple deficiencies, for besides fibrinogen and factor V, probably prothrombin, factor VII and Stuart factor are also

susceptible to the proteolytic action of fibrinolysin. Dr. Wagner here has clearly demonstrated that AHF can also serve as a substrate for this enzyme.

In a given patient with fibrinolytic activity, we do not necessarily have to find a reduction in all these factors, but often only some of them are definitely low. As an example I might mention a 72-year-old man whom I recently studied. There were repeated episodes of fibrinolysis and massive hemorrhage, with decreased levels of prothrombin, factor V and Stuart factor, but with a normal level of AHF. It is possible that the AHF level had been low initially, but had already come back up to normal at the time of our studies.

Dilution

DR. GERATZ: I would like to ask Dr. Talbert one question not related to the clotting defect. How did you explain the drop in the hematocrit by 10 points within the first two days after admission? There was apparently not sufficient external blood loss to account for this, nor was there evidence of hemolysis.

DR. L. M. TALBERT: We were somewhat at a loss to explain this. When the patient was admitted, she appeared dehydrated

and therefore she received goodly amounts of intravenous fluids. I think that dilution may have accounted for at least part of the change in the hematocrit.

DR. BRINKHOUS: In summary, this case has focused our attention on the bleeding diathesis that occurs as a complication of hydatidiform moles. The patient presented with a deficiency of many of the clotting factors, and we have to assume that several pathogenetic mechanisms were at play to give the rather complex picture observed:

- *Thromboplastinemia.* Necrotic material from the degenerating mole may gain access to the blood stream and act as thromboplastin. Intravascular clotting with fibrin deposits and depletion of several coagulation factors will result.

- *Fibrinolysis.* Fibrinolysin may be activated by tissue fibrinolysokinases liberated into the blood and possibly by the intravascular clotting process also. Fibrinolysin, a proteolytic enzyme, will split fibrin molecules as well as other clotting factors.

- *Vitamin K deficiency.* Insufficient supply of vitamin K will lead to decreased levels of prothrombin, factor VII, PTC

and Stuart factor, because the liver can manufacture these materials only in the presence of the vitamin.

- *Liver damage.* Hepatocellular damage can result in a deficiency of all factors produced by the liver whether their formation is dependent on vitamin K or not.

Of the pathogenetic mechanisms suggested, it appears that initially episodes of thromboplastinemia occurred. There may have been an associated fibrinolysinemia, but we can form no definite opinion from the data available. Liver damage likewise may have been of importance. Certainly vitamin K deficiency was present, as indicated by the prompt response to administration of the vitamin. The uterine hemorrhage of this patient was probably related to local factors as well as to the disturbance of the clotting mechanisms. Hematuria was also suggestive of a clotting defect.

I know of only one reported case of hemorrhage and widespread intravascular clotting with hydatid mole. It would seem indicated to study carefully the levels of the various coagulation factors in any future cases of moles.

Robert R. Cadmus, M.D.



Guest Editorial

The Hospital is Inside

Unlike ancient civilization, our culture scorns the worship of idols, yet at times we tend to overrate the inanimate. There is the story of a great university which built a fine new library. It was a monumental structure with tall columns, beautiful stonework, marble floors, and ornate furnishings. As students and faculty escorted visitors through the campus, they all boasted: "This is our new library," and they admired the imposing edifice. Finally, the librarian could stand these remarks no longer and he posted a big sign in front of the building saying: "This is not the library. The library is inside."

I would say the same for hospitals. The building is not the hospital. The hospital is inside. It includes the people just as the library includes the books, because what books are to libraries, people are to hospitals. The better the books, the better the library. And likewise, the better and more dedicated the people, the better the hospital.

Unfortunately, however, hospitals are a bit more complex than libraries. People have emotions, and prejudices and breaking points and are creatures of

motivation and stimulation. They don't sit quietly on shelves awaiting to impart to others their unique message however worthy or however insignificant.

As Gordon Davis, one of the leading publicists in the health field recently wrote: "Hospitals are motivated like a charity, operated like a business, regulated like a profession and governed like nothing else in our society."

It is little wonder then that at times, the people within the hospital—the very people who breathe life and spirit into the inanimate building—find themselves involved in petty interpersonal problems and frictions. In few human endeavors are the actions of one person so important in the simultaneous actions of so many different people. The surgeon dressing a wound in the emergency room depends upon the nurse to have the proper size dressing ready for him at his command; the central sterile supply room for having sterilized it safely; the storeroom for having delivered it to the right department; the purchasing department for its procurement and for anticipating the proper delay in delivery; and the accounting department for having the necessary funds to pay for it when the bill comes due.

All of these people had to do their jobs even before the patient who needed it, ever made his fateful misstep. In such a chain reaction, it is inevitable that sooner or later there will be some unfortunate human error—the delivery will be late, the sterilizer will break down, an order will be misunderstood, or some other distressing situation will rear its explosive head.



ROBERT R. CADMUS
Director,
North Carolina
Memorial
Hospital

Every effort, of course, should be made to minimize such difficulties, by effective administration. However, if they do occur, the real test of the hospital and of ourselves comes when we react to such "trigger" situations. If we constantly go around looking for others to blame or to criticize, or remain ignorant of the full and often extenuating circumstances, rather than trying to help, to correct and to understand, the hospital will become a tense, unpleasant place in which to work. It will also be an unlikely place in which to find the relaxed environment conducive to ideal recovery. Rigid rules will replace common sense and individual judgment. The heart, the friendliness, and the warmth so necessary in a hospital will be chased out of the very doors which should be known for their tenderness and their mercy.

Leo Tolstoi, in his essay "The Fundamental Law of Human Life" seemed to have sensed this possibility when he wrote: "It all lies in the fact that men think there are circumstances when one may deal with human beings without love, and there are no such circumstances. One may deal with things without love, one may cut down trees, make bricks, hammer iron, without love; but you cannot deal with men without it, just as one cannot deal with bees without being careful. If you deal carelessly with bees, you will injure them and will yourself be injured. And so with men."

I can only add, "and so with hospitals."

THE NORTH CAROLINA MEMORIAL HOSPITAL

TO SERVE AS A CONTINUING
MEMORIAL TO THOSE NORTH
CAROLINIANS WHO HAVE GIVEN
THEIR LIVES AND WHO MAY
HEREAFTER GIVE THEIR LIVES
AS MEMBERS OF THE ARMED
FORCES IN PROTECTING THE
FREEDOM AND COMMON
WELFARE OF THEIR FELLOW
CITIZENS



University of North Carolina

**Boasting one of the
most modern physical plants
in the nation,
this state-supported center
offers training and
research opportunities
in 17 specialties
to 158 house officers.**

It was in 1879, three years before Koch discovered the tubercle bacillus and long before most universities recognized their obligations in the field of health, that the University of North Carolina began its program of medical education.

At first, the fledgling School of Medicine offered only a course in theoretical and practical medicine in line with the preceptorial system of medical education then in vogue.

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North Carolina Medical Center

Gradually, the School expanded, paralleling the development of North Carolina as a State and of the University as a leader of higher education in the South. The University of North Carolina, the oldest state university in the nation, (1795) could well assume this expanding responsibility.

Yet, in 1910, about the time that Abraham Flexner made his monumental study of this country's medical schools, the Univer-

sity thoughtfully dropped the clinical years and concentrated on offering a sound and nationally recognized two year program in the basic sciences. Consequently, from 1911 to 1952, the School of Medicine offered this limited curriculum at Chapel Hill and its students were transferred to the leading four-year schools of medicine throughout the nation for the completion of their medical training. Approximately 25 percent of the physicians now in ac-





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tive practice in North Carolina received their preclinical years of professional training at this University.

The stimulus for the return to a full four year curriculum dates back to 1944 when the medical and civic leaders of the State brought forth the "Good Health Movement" with its slogan of "More Doctors, More Hospitals and More Insurance." Dean W. Reece Berryhill of the School of Medicine was among those visionaries who sparked this far-reaching program.

Time for action

As a result of this highly organized campaign, extensive studies and surveys were made by local and national committees, all culminating in 1947 when the State established the 400-bed North Carolina Memorial Hospital. Subsequent funds provided for the enlargement of the Medical School Building, a new School of Nursing, School of Dentistry, 54-bed Psychiatric Center, 100-bed Tuberculosis and Chest Disease Hospital, and for residence halls for nurses and for the resident staff.

This authorized expansion was designed not only to re-establish at Chapel Hill a full four year curriculum in medicine, but also to create within the University the educational facilities necessary to train needed health personnel in all categories which were, with some literary license, lumped into the "More Doctors" part of the campaign slogan.

Health affairs

These decisions created at the University of North Carolina, one of the five truly complete medical centers in this country having all major professional schools. The Schools of Medicine, Nursing, Dentistry, Pharmacy, and Public Health, along with the North Carolina Memorial Hospital and a library, are organized as a Division of Health Affairs within the University's academic structure. The library, located in the Clinic Building, contains approximately 65,000 volumes and receives regularly 1,100 domestic and foreign medical and scientific journals.

The Hospital is an integral part of the School of Medicine. Its director, Robert R. Cadmus, M.D., also serves as chairman of the Department of Hospital Administration. Because of this administrative organization, the

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Hospital maintains an intimate relationship to the program of medical education. Chapel Hill being a small college town would in itself not require a hospital of the size and complexity of the North Carolina Memorial. Actually, in neighboring Durham, only 10 miles away, there are more than 1,500 excellent general medical and surgical beds including the Duke University Hospital.

Facilities

However, the North Carolina Memorial Hospital came into existence primarily as the clinical laboratory for the School of Medicine, and as a referral center for all of North Carolina. The referral basis for admission brings a broad range of interesting pathological conditions which in turn speeds up the tempo of care since these complex clinical problems require unusually heavy diagnostic and therapeutic procedures. The local neighborhood adds sufficient community - type diagnoses to create a balance on all clinical services.

North Carolina Memorial Hospital was appropriately designated the State's memorial to its war dead—a living memorial to their sacrifice. Construction was begun in 1949 and the first pa-



YOUNG AND OLD Tender loving care, vital ingredient of hospital program, is enhanced by the thousands of hours given by volunteers. Below, patient nearing century mark shares advantages of Memorial's modern facilities.



tients were admitted on September 2, 1952. Simultaneously, the School of Medicine once more admitted a third-year class and in 1954 again granted the M.D. degree.

The building currently has 384 beds, 70 percent assigned to the staff services, the remainder being reserved for private patients. Last year some 10,281 admissions were recorded.

Ambulant care

Considerable emphasis is given to ambulatory and home care programs. There is an active staff outpatient department, organized around a General Clinic, originally aided by a grant from the Commonwealth Fund, which cuts across the usual departmental lines to offer comprehensive care to the ambulant patient.

The private patient service is organized to offer similar ambulatory care to the individual desiring a private physician. An Intermediate Clinic in pediatrics and in obstetrics, staffed primarily by residents but operated like private practice, handles dependents of students and house officers. A large Psychiatric Clinic in separate quarters handles this special group of patients using many traditional, as well as experimental, techniques. An ac-

tive emergency ward brings the total ambulatory visits to well over 116,000 a year.

The Home Care Program is, of course, restricted to the immediate local area and is organized primarily as an education experience.

The Hospital maintains every professional and subprofessional department listed by the American Hospital Association and is approved by the Joint Commission on Accreditation of Hospitals. The blood bank is one of two such facilities in North Carolina licensed by the National Institutes of Health to ship blood and plasma across state boundaries. Hospital departments such as pharmacy, social service, clinical psychology, physical therapy, and the clinical laboratories are also integrated with academic programs in these professional specialties. The total hospital operation is staffed by 900 paid employees, exclusive of students and attending physicians.

Faculty

The Basic Science Faculty of the School of Medicine exceeds 70 full-time individuals, housed in the School's Basic Science Building adjacent and connected to the North Carolina Memorial Hospital. The Clinical Faculty

NORTH CAROLINA MEMORIAL HOSPITAL INTERNSHIPS AND RESIDENCIES

INTERNSHIPS	CHIEF	NO.	LENGTH
MEDICINE	C. H. Burnett	12	1
MIXED (MEDICINE & PEDIATRICS)	J. D. Dorsett	9	1
PATHOLOGY	K. M. Brinkhous	4	1
PEDIATRICS	E. C. Curnen	4	1
SURGERY	N. A. Womack	6	1
RESIDENCIES			
ANESTHESIA	D. A. Davis	4	2
DERMATOLOGY	J. M. Hitch	1	2
GENERAL PRACTICE	J. D. Dorsett	3	2
INTERNAL MEDICINE	C. H. Burnett	16	3
NEUROLOGY	T. W. Farmer	3	3
NEUROLOGICAL SURGERY	G. S. Dugger	2	4
OBSTETRICS & GYNECOLOGY	R. A. Ross	12	3
OPHTHALMOLOGY	S. D. McPherson	2	3
ORTHOPEDIC SURGERY	B. R. Raney	3	3
OTOLARYNGOLOGY	N. D. Fischer	2	3
PATHOLOGY	K. M. Brinkhous	7	4
PEDIATRICS	E. C. Curnen	8	2
PSYCHIATRY	G. C. Ham	36	3
RADIOLOGY	E. H. Wood	9	3
SURGERY	N. A. Womack	15	4
THORACIC SURGERY	R. M. Peters	1	1
UROLOGY	P. L. Bunce	1	3

numbers 235 members. Although 133 are part-time staff members from throughout the State who participate in various teaching exercises, the senior attending staff of 102 is on a full-time geographical basis.

There is no courtesy staff; all physicians admitting patients to the North Carolina Memorial Hospital are members of the Faculty of Medicine. Consequently, student and house staff teaching is conducted by academically oriented physicians.

PLEASANT INTERLUDE Welcome break from hospital routine is given these youngsters at impromptu lawn party.



Research is supported by Faculty research grants totaling over \$1 million dollars a year in all phases of basic science and clinical research, plus \$600,000 annually received in grant support of special teaching and training programs. This year, research grants are divided among 159 identifiable projects.

Hemophilia

Of interest (because of the "Symposium on Coagulation Disorders" presented separately in this issue of RESIDENT PHYSICIAN) is our Hemophilic Dog Colony which is unique in this country. The Department of Pathology maintains an inbred strain of dogs with hemophilia which has been kept as a pure colony for many years. A new Blood Research Laboratory has recently been constructed with financial help from the Hemocardiac Foundation, The Hemophilia Research Foundation and the United States Public Health Service to continue this valuable animal and clinical experiment. Since the medical care program is interrelated with the research and educational program, the house officers and medical students are not only close to, but often participate in, many of these projects.

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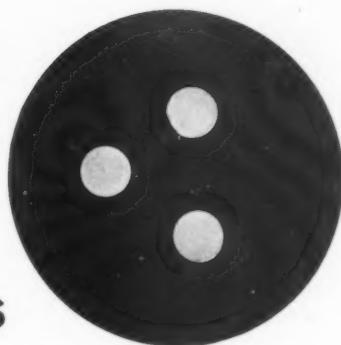
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nitrofurant

FUROXO
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furazolidon

FURACIL
brand of
nitrofurazo

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NITROFU

AN IMPORTANT STATEMENT ON BACTERIAL SENSITIVITY TESTING WITH THE NITROFURANS



The individual nitrofurans—ALTAfur, FURADANTIN, FUROXONE, FURACIN—are not interchangeable either in clinical application or in susceptibility testing. Although chemically related, these compounds differ to a highly significant degree in their range of antibacterial activity as well as in solubility, diffusion rate, and other physical characteristics. For this reason, SENSI-DISCs* containing each of these nitrofurans are provided for appropriate disc plate testing. *Results are valid only for the compound tested.* Cross-interpretation will lead to erroneous conclusions.

Nitrofuran	Antibacterial Spectrum	Clinical Application	For Disc Plate Test Use
ALTAfur® (brand of furaltadone)	Wide. Particularly effective against staphylococci, including antibiotic-resistant strains.	Systemic infections, including those of the respiratory tract and soft tissue. (Rapidly absorbed, low urinary excretion.)	ALTAfur SENSI-DISCs*
FURADANTIN® (brand of nitrofurantoin)	Wide. Highly active against urinary tract pathogens.	Urinary tract infections. (Rapidly absorbed, high urinary excretion.)	FURADANTIN SENSI-DISCs*
FUROXONE® (brand of furazolidone)	Wide. Especially effective against enteric pathogens.	Enteric infections. (Minimal systemic absorption.)	FUROXONE SENSI-DISCs*
FURACIN® (brand of nitrofurazone)	Wide. Encompasses most surface pathogens.	Used topically only.	FURACIN SENSI-DISCs*

*Available from the Baltimore Biological Laboratory (Division of Becton, Dickinson & Co.), Baltimore 18, Md.

NITROFURANS—a unique class of antimicrobials—EATON LABORATORIES, NORWICH, NEW YORK

Because of the receipt of a recent National Institutes of Health Research grant entitled: "Improving Hospital - Physician Relations Through Education," the North Carolina Memorial Hospital will become a center for objective investigation of this sensitive professional relationship.

The parade of nationally and internationally recognized individuals and members of "travel clubs" who are attracted to Chapel Hill because of research projects, speaking engagements, or participation in formal or informal service or educational programs reads like a "Medical Who's Who." Indeed, the North Carolina Memorial Hospital stands on one of the busy medical corners of the southeast.

Progressive patient care

North Carolina Hospital has three of the elements of progressive patient care—intensive care, intermediate care and home care—and is actively studying the self-care and chronic care concepts. These developments have come as a result of the Hospitals' emphasis on referral type patients.

Having a "sicker house" than the average hospital, or even the typical teaching hospital, presents certain problems and offers certain opportunities.

In 1953, the North Carolina Memorial Hospital, in order to better handle the more seriously ill patients, pioneered the concept of a special care or intensive care unit and was the first hospital to report this type of practice in the hospital literature. Currently, a new 32-bed Special Care Unit is being remodeled. The same broad concepts of progressive patient care have been carried into the Premature Nursery which is in reality a special care unit for newborn infants. To this unit are admitted not only those infants who by definition are premature, either by period of gestation or by birth weight, but also infants requiring replacement transfusions, surgery for congenital defects, and other medical or surgical complications in the immediate neonatal period. Infants born with oral clefts often undergo surgical repair within the first few hours of life and are shown to the mother only after the repair has been completed. Rehabilitation has been an active part of the program, stimulated in part by a generous grant from the National Foundation for Infantile Paralysis.

The admission of psychiatric inpatients has been an important part of the NCMH program from the very beginning. A separate wing known as the Psychiatric

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READING AND REFERENCE N. C. Memorial's library provides house staffers with an opportunity to study in comfortable surroundings. Shown here is a section of the library's large reading room.

Center has accommodations for 54 inpatients plus large outpatient facilities. The program of this Center is closely allied with that of the mental hospitals of the State of North Carolina and accordingly, service, research, and undergraduate and postgraduate educational programs are integrated. This has had a dramatic effect on upgrading the quality of care in the custodial institutions for psychiatric patients.

A similar arrangement exists with the 100-bed Gravelly Tuberculosis Hospital which is connected to the North Carolina Memorial Hospital by tunnel but which, administratively, is a branch of the State Tuberculosis

System. The North Carolina Memorial Hospital provides surgical, laboratory, and other facilities for this group of specialized patients and, in turn, they are used for medical education. The medical Faculty serve as attending physicians to this closely integrated institution.

Training programs

The Hospital offers approved internships in medicine, surgery, pediatrics, pathology and a mixed program designed for the general practitioner as well as residency programs in 17 specialties: anesthesiology, dermatology, general practice, medicine, neurological surgery, neurology, obste-



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"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."⁴

well tolerated — On a "start-low, go-slow" dosage pattern DBI is relatively well tolerated. DBI enables a maximum number of diabetics to enjoy the convenience and comfort of oral therapy in the satisfactory regulation of . . .

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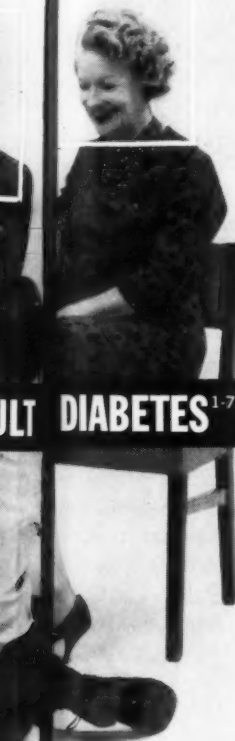
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trics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, psychiatry, radiology, surgery, thoracic surgery, urology.

In all, there are 158 house staff positions, including fellows and special trainees.

Internships are awarded through the National Internship Matching Program and the residencies on an individual basis.

Most programs start on July 1, but starting dates at other times can be arranged. Appointments are available to both men and women, and house staff rosters represent graduates from medical schools throughout the nation. Foreign graduates must be certified by the Educational Council for Foreign Medical Graduates.

Salaries start at \$1800 for an intern and go to \$4000 for a resident, although there are many opportunities for higher stipends in certain specialty areas. The Hospital operates on a cash basis and rooms, board, and laundry are available at modest prices.

The Research Triangle of North Carolina is a scientific organization offering to research-minded industry a unique location for research facilities. It offers a research park geographically located in the center of an outstanding academic triangle,

bounded by North Carolina State College in Raleigh, Duke University in Durham, and the University of North Carolina at Chapel Hill. This brings a large group of research and scientific oriented individuals to the immediate area who, in turn, use cooperatively the academic talent of the universities.

A Univac 1105 Research Computer Center has recently been installed at the University and offers computer potential to the campus and to the entire southeast. The equipment will be used, in part, for the 1960 Federal Census but ample capacity will be available for all types of research projects.

Chapel Hill

Chapel Hill, affectionately known as the "southern part of heaven," is a relatively small university community which is renowned for its gracious living and cultural opportunities. Many retired individuals find their way to the community and even in retirement, contribute to its strength and its vitality. The Carolina Inn is a University-operated hotel which is available for all guests and visitors to the community. The Morehead Planetarium is one of six such installations in the United States and



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answer the question of how to treat the patient allergic to tree pollens. (Birch, hickory and oak are the most important offenders, and oak is the most abundant.) With POLARAMINE REPETABS — today's lowest-dosage antihistamine — you can control rapidly and safely the annoyance and discomfort of seasonal or nonseasonal allergies, allergic dermatoses, allergic complications of respiratory illnesses, and drug and serum reactions.

Histamine is present in most tissues of the body, but it is concentrated in those body areas exposed to contact with the external environment: the skin, the respiratory tree, and the upper gastrointestinal tract. When an antigen, whether from tree pollen or any other allergenic substance, provokes an antibody response, histamine is released, and the familiar symptoms of allergy follow. POLARAMINE — in *any* form — controls these allergic reactions by blocking the access of histamine to receptor sites, and POLARAMINE does this at dosages lower than those necessary with other available antihistamines.

POLARAMINE REPETABS (4 mg. and 6 mg. dosage forms for your patients' convenience) and POLARAMINE Tablets (2 mg.) are unrivaled in effectiveness and safety. The rapidity of action for which POLARAMINE is noted is also important to the physician. Summarizing treatment of a recent group of 100 allergic patients, Babcock and Packard report that POLARAMINE REPETABS were "... especially effective in patients who presented sudden, acute allergy symptoms."*

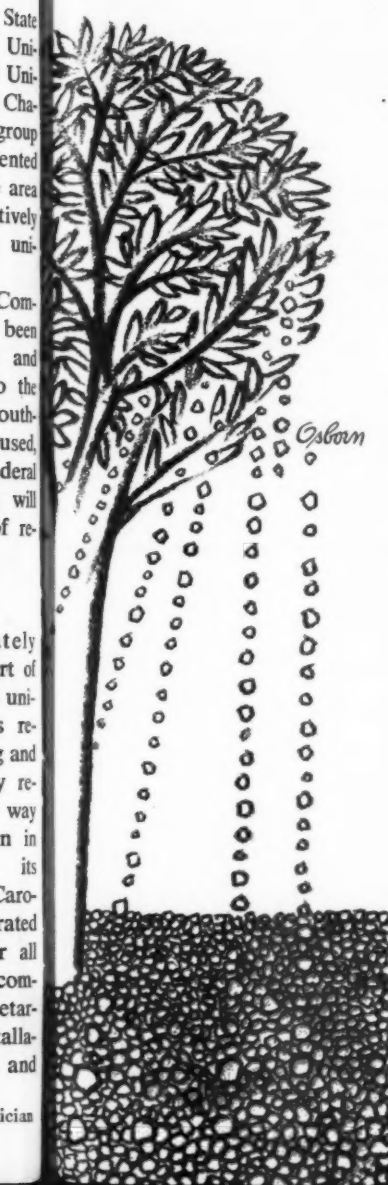
Remember also that POLARAMINE Syrup — it tastes good — is a great help in treating the young allergic patient or those who prefer liquid medication.

Dosage: REPETABS, 6 mg. and 4 mg. — One REPETAB in the morning and one REPETAB in the evening. Tablets, 2 mg. — One t.i.d. or q.i.d.; children under 12, one-half tablet t.i.d. or q.i.d.; infants, one-quarter tablet t.i.d. or q.i.d. Syrup, 2 mg. per 5 cc. — Adults, one teaspoonful t.i.d. or q.i.d.; children under 12, one-half teaspoonful t.i.d. or q.i.d.; infants, one-quarter teaspoonful t.i.d. or q.i.d.

Supply: POLARAMINE REPETABS, 6 mg., bottles of 100 and 1000; 4 mg., bottles of 100 and 1000. Tablets, 2 mg., bottles of 100 and 1000. Syrup, 2 mg. per 5 cc., 16 oz. bottles.

*Babcock, G., Jr., and Packard, L. A.: *Clin. Med.* 6:985 (June) 1959.

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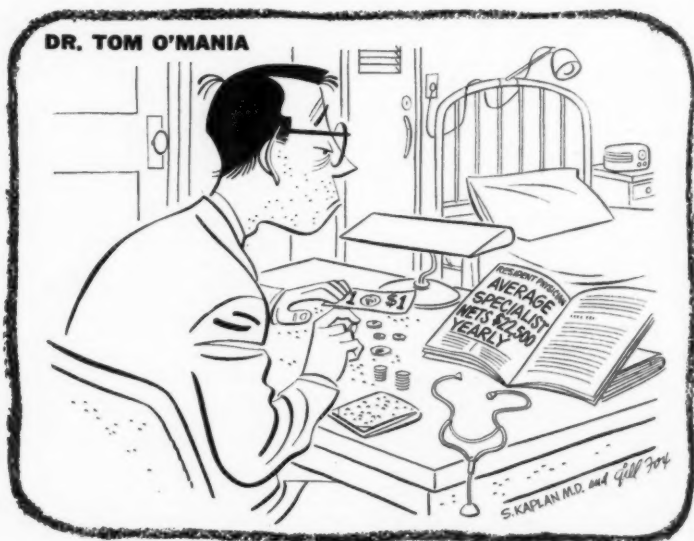


the only one on a university campus. The Ackland Art Museum offers a continuing showing of fine art. The North Carolina Symphony Orchestra, the only state-operated orchestra in the nation, has its headquarters on the campus.

The talk of athletics is always in the air and the "win-loss" record usually sufficiently satisfactory to be considered in the collegiate "big league." Playmakers Theatre offers an outstanding bill of local and Broadway talent.

Home and apartment construction has kept up with demand

so that most married house officers can find housing of their choice without great difficulty. There are many lovely churches, representing every major faith and a number of fine new schools. There is almost unlimited opportunity for employment for working wives. The University, consisting of 14 colleges and schools, some 70 departments and numerous other institutes, divisions and other academic affiliated organizations, employs student resident and faculty wives in a wide variety of clerical and professional positions.



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Child Cardiac Unit to Open

Heart Study Center Completed—Children with heart disease of every type will be studied from infancy through adolescence at New York University-Bellevue Medical Center's new cardiac diagnostic unit to be opened this month.

A memorial to the late Dr. Janet S. Baldwin, associate professor of pediatrics at the Medical Center and pioneer in diagnosis of congenital cardiac anomalies in children, the unit will include facilities for cardiac catheterization and cine angiocardiology and will be under the direction of Dr. Edmund H. Reppert, assistant professor of clinical medicine at the medical school.

Grant Made for Calcium Study

Two-Year Program Ready—A research grant of \$241,150 by the John A. Hartford Foundation, Inc., of New York has been made to Presbyterian Hospital in Philadelphia for a study of calcium metabolism and the development of chelating techniques for the treatment of calcareous cardiovascular diseases.

The grant will be used over a two-year period to assess the potential value of chemical agents which can bind and safely remove undesirable calcium deposits from the system, providing a means for treating arteriosclerosis. The program will be conducted by Drs. J. Roderick Kitchell and Lawrence E. Meltzer.

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Since "... dysmenorrhea is a symptom complex which has no one particular origin . . ."¹ tranquilaxant therapy, directed at *two* factors, has been particularly successful in alleviating menstrual pain and discomfort. The tranquilaxant, Trancopal "... combines the properties of tranquilization and skeletal muscle relaxation, with no concomitant change in normal consciousness."²

"... able to continue their normal activities . . ."³

Good to excellent results with Trancopal were obtained by Lichtman^{3,4} in 139 of 173 patients with dysmenorrhea and premenstrual tension.⁴ They "... had not only their symptoms controlled with chlormethazone [Trancopal] but, even more important, the patients were in many instances able to continue their normal activities where previously they had been considerably restricted in their activities."³

Stough⁵ studied 75 patients during 125 menstrual periods and found that complete or moderate relief with Trancopal was obtained during 86.4 per cent of the periods.

Shanaphy² reported satisfactory results with tranquilaxant treatment with Trancopal in 41 of 50 patients with dysmenorrhea; 20 of these patients had been refractory to other methods of treatment.

"Side effects were noticeably absent . . ."⁵

Dosage: 100 or 200 mg. orally three or four times daily.

How Supplied: Trancopal Caplets®

100 mg. (peach colored, scored), bottles of 100.

200 mg. (green colored, scored), bottles of 100.

References: 1. Woodbury, R. A., in Drill, V. A.: *Pharmacology in Medicine*, ed. 2, New York, McGraw-Hill Book Company, Inc., 1958, p. 1003. 2. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 3. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 4. Lichtman, A. L.: Scientific Exhibit, International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 5. Stough, A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

Trancopal

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1453M

From a special conference on internship held at Michael Reese Hospital and Medical Center, your Journal brings you this timely article by Dr. Victor Johnson, a principal speaker. This is the second of three articles on the subject of internships which were presented at the conference. The first, by Dr. Hugh Luckey, was published last month. The final article, by Dr. Richard Saunders, will be in next month's Resident Physician.

Resident Physician is indebted to the administration and staff of Michael Reese Hospital for making this article possible.

THE FUTURE OF T

I think we may safely say that the internship has been slandered, beaten, read out of court, kicked, slugged and burned in effigy. But the internship is a cat with nine lives, a phoenix arising from the ashes, a ghost which persistently walks to torment its assassins.

The past decade or two has seen more symposiums on the internship, more surveys, more analyses, more reports, more resolutions in the A.M.A. House of Delegates, and more conferences than perhaps any other segment of medical education. If all the detractors of the internship in a given year were laid end to end, wouldn't that be nice!

Maligned, though it is, the internship has persisted as the most sought-after elective in the entire curriculum of medical education. In 1913 no medical school or state examining board required the internship for the M.D. degree or for licensure.

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REVIEW OF THE INTERNSHIP

Victor Johnson, M.D.

Pennsylvania was the first state to require the internship for licensure (1914) and the University of Minnesota was the first school to require such training for the M.D. degree a year later.

Requirement

However, the value of the internship was widely recognized by students, physicians and medical schools.

Before these first requirements for licensure and graduation were instituted, 70 percent of the graduates elected to take internships voluntarily, nearly a half century ago.

The internship as a formal requirement was adopted to an increasing degree following the first actions of the State of Pennsylvania and the University of Minnesota. For a time both medical schools and licensing bodies exacted this requirement in increasing numbers, so that by 1936

there were 15 medical schools and 19 states requiring an internship.

Subsequently the relationship of the internship to the medical schools and to the licensing authorities was reassessed. Medical schools began to be dissatisfied with the internship as a requirement for a degree, while still recognizing it as an essential in the education of a physician. Medical schools felt that there was little justification for requiring work in an institution not under the control of the university, and often located at a great distance, in partial fulfillment of requirements for the M.D., a university or medical school degree. There followed a period in which this

Dr. Victor Johnson is director of the Mayo Foundation for Medical Education and Research, and a member of the Internship Committee, American Medical Association.

requirement was abandoned by almost all medical schools.

Elective

But the internship stubbornly persists as an elective. It is an elective demanding hard work, long hours, financial sacrifice and dedicated service. It is no "snap course." Even today, an internship is not required for licensure in 17 states in this country with a total population of more than 77,000,000 people. These include such populous, wealthy and enlightened states as Indiana, Massachusetts, Texas, Ohio and New York.

In the states not requiring the internship there are more than 100,000 physicians—nearly half of the physicians (total 226,625) in the entire country. It would be safe to estimate that only a relative handful of these 100,000 physicians who are in active practice have not had an internship.

Despite this lack of legal compulsion for the internship, only insignificant numbers of medical school graduates choose to enter practice anywhere without the elective experience of the internship. The election of an internship represents a dictate of conscience rather than a compulsion of law.

I am aware that in today's con-

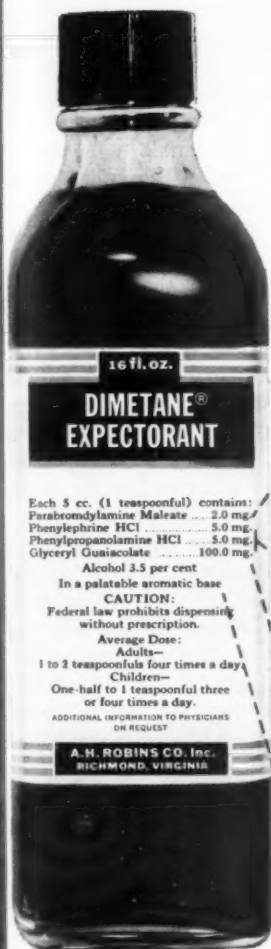
ference we are not discussing primarily whether to abolish the internship, but rather we are debating the relative merits of the straight versus the rotating internship. Yet the two problems are intimately related, because the straight internship becomes pretty much the first year of residency.

Intermediate

A logical, convincing case can be made for discontinuing the traditional internship altogether because the medical student today, as an extern, does many of the things thought to be exclusively in the province of the internship 30 years ago.

At the same time, many more graduates are now taking residency training. In 1958 there were nearly 21,000 residents in approved training programs, as compared with about one-fourth that number (5256) less than 20 years ago.

Consequently, it may be argued that the transition in a physician's clinical experience from the clerkship to the residency does not require the intermediate intern experience. Or, at least in medical school hospitals, the work and responsibilities of the intern are encroached upon so much from the extern below and from the resident above that



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there is left very little room for the intern.

Outmoded

The argument is attractive.

Most groups of medical educators studying the internship arrive at some such belief early in their discussions. I was privileged to work a few years ago with a distinguished group appointed by the Council on Medical Education and Hospitals of the American Medical Association to review the place of the internship in medical education and make recommendations concerning the future of this educational experience.

The first discussions of this committee centered about the theme that the internship is probably outmoded, squeezed into oblivion by the dual pressures of the clerkship and the residency. To the committee, it appeared that "twenty-five years ago, the place of the internship was clear. Following upon a medical school curriculum which was centered around the laboratory and amphitheater rather than the bedside, it was a big step toward assuming clinical responsibility for the individual patient.

"Residencies were few and far between. In their place stood advanced experience in the second year of many internships. In this

second year often a man would carry out 50 or more supervised major surgical procedures or be in direct charge of a considerable group of ward and outpatients.

"Contrast today's intern. With the modern superstructure of residencies which has followed establishment of specialty boards, rarely can he achieve significant clinical responsibility. . . . Yet, if he comes from a school with modern, well-developed clinical clerkships, he enters his internship far more versed in practical matters than did his father's generation. Already he has taken many histories, done many physical and routine laboratory examinations, and presented his patients for scrutiny on teaching rounds. He is familiar with the second assistant's position at the operating table. He has probably done a thoracentesis, a spinal puncture, and other minor surgical procedures."

Questions

Someone had the good sense to suggest that the advisory committee on internships inquire of many recent medical graduates for their appraisal of the role of the internship in their education. Specific questions were put to several thousands of medical school graduates of the classes

of 1937 and of 1947. These questions were:

- Did your internship provide significantly more advanced experience than that which you had as a student clinical clerk?

- Do you believe the internship is still essential in medical education?

- What type of internship would you have taken (if you had had complete freedom of choice)?

- How would you rate your internship in terms of its educational value to you?

Value

It was learned that about 90 percent of the graduates of 1947, queried in 1952, five years after graduation, felt that the internship provided a real increase in responsibility as compared with the experience of the externship.

Those who had a straight internship were a little more positive in this assertion than were the graduates who had a rotating internship. Perhaps this might be judged as evidence favoring the straight internship.

It also seemed clear that medical school graduates, after five years of reflection and experience were overwhelmingly convinced that the internship is essential in medical education.

Again, those who had straight internships were slightly more positive than the others, but the striking opinion emerges that more than 97 percent of recent medical school graduates judged the internship to be necessary, viewed from a distance of five years.

Perhaps the improvements and developments in clerkships and the still further expansion of residencies in the six years since this study was completed have diminished the positive support for the continuation of the internship.

Conversations with our residents at the Mayo Foundation seem to question whether the findings reported need significant modification. In residence training in Rochester we have nearly 600 physicians, representing at any one time three-fourths of the medical schools of the United States and Canada. We have no interns.

No systematic study has been made of the appraisal of their internship by our residents, but the impression is gained that the internship has been mainly a valuable experience intermediate between the clerkship and the residency. Almost all our residents have had rotating internships.

Rating

Of considerable interest in the study of the advisory committee on internships was the reaction of interns to the presence of clerks and residents. The highest rating of internships of "excellent" was made by interns in hospitals with both externs and residents. A rating of "excellent" was significantly less frequent when neither clerks nor residents functioned in the hospital.

Admittedly hospitals having both externs and residents are medical school hospitals where there is general devotion to teaching by the staff; in such institu-

tions a climate of inquiry and study and learning is fostered. At any rate, these data provide no evidence for clerkships and residencies devaluing the worth of the internship or diminishing its educational content.

Rotating or straight

It should again be stated that judgments about the relative merits of a straight versus a rotating internship cannot be separated from conclusions about abolishing the internship.

General adoption of the straight internship would approximate eliminating the internship

NEWS ROUNDS

New Program in Cleveland

Training for Internists. A training appointment in internal medicine that "departs from the usual pattern in many of its aspects" is offered by the Cleveland (Ohio) Clinic Foundation, it was announced by Charles L. Leedham, M.D., director of education. The appointment, called a "Clinical Traineeship," is for one year and is designed particularly for the medical resident who has completed two years in an approved program and who wants to devote his third year to a clinical experience which stresses office diagnoses and the management of private patients. According to Dr. Leedham, the training is conceived as a transition between hospital medicine and individual private practice.



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**A Century
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From the following list select and number in order of importance reasons you held at the time for selecting the particular hospital (or federal service) in which you interned.

ORDER	NUMBER	REASON
1	1617	Reputation of hospital
2	1016	Affiliated with medical school
3	937	Intended practicing in community
4	937	To secure residency appointment
5	677	Desire for association with staff members
6	521	Stipend offered
7	330	Hospital's research activity
8	314	Not affiliated with medical school
9	99	Planned federal service career
10	502	Other reasons

in favor of the first year of a residency program.

The evaluations by young physicians of their internships, straight or rotating, was one of the most revealing findings of our study. Nearly all—93.5 percent—physicians who had rotating internships indicated five years later that they felt they had chosen the right kind of internship.

By contrast, more than one-third of those who took straight internships thought that rotating internships would have been better.

Only 60 percent of those with the straight service were well satisfied with this kind of experience. Equally striking, there were nearly eight times as many physicians in rotating services as there were in straight internships.

Content

It would seem that the teaching content of the internship experience is more important to the medical school graduate than is the nature of the internship, straight or rotating. The reputation of the hospital as a good

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place to intern, and its affiliation with a medical school were two factors more important than others in determining the selection of an internship hospital by the medical student. Rank order of reasons can be seen in the table on page 134.

Teaching Quality

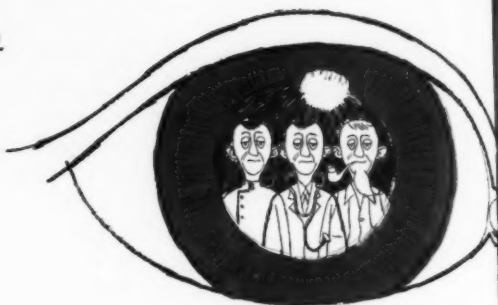
And here we arrive at the crux of the problem. It is the quality of teaching which is the major factor in determining the value of any educational enterprise, whether it be in a premedical physics course, a biochemistry laboratory, a clinical clerkship, an internship—straight or rotating—or a residency experience.

Quoting again, from S. Howard Armstrong, "the basic essential of a good internship is a staff of skilled clinical teachers, who in their maturity have remained students of medicine and are engaged in patient care in the atmosphere of critical thought and free communication. We believe that internships should be offered by hospitals in which such men, devoted to their daily teaching, are

concentrated. . . . Whether a hospital has or has not university affiliation, whether the patients are chiefly in private rooms or public rooms or public wards, whether it is in a metropolis or a rural area makes little difference to an internship, given such a staff. In the absence of a capable staff, directors of intern education and elaborate didactic programs are useless; considerations of service structure and of rotation schedules are likewise meaningless."

Necessary supplement

The internship is probably still a necessary educational experience supplementing the medical school clinical clerkship. However, it should be one goal of undergraduate medical education to so strengthen the clinical externships that the internship may be eliminated by physicians progressing into residencies. For physicians not entering specialty training, there will probably continue to be a need for a one-year and perhaps a two-year rotating internship.



An O. R. Nurse Looks at You...

"In the beginning, Doctor, you had me utterly, completely dazzled! You might have been either a medical student, intern or resident, for the significance of medicine's hierarchy had yet to dawn on me. I only know that to my eighteen-year-old eyes you were the most divinely handsome creature I'd ever encountered . . . a REAL doctor!"

Margie Warner

I wouldn't expect you to remember the incident, but how well it has remained with me. It was a big day right from the beginning. I was entering the hospital ward for the very first time as a full-fledged, preclinical student nurse—quite proud, even, of my black cotton stockings.

And now my turn had come to demonstrate to my nursing arts instructor my skill at wielding a washcloth on a living patient. She had wisely led me to the medication room to wait (here I could stay out of trouble, she thought) until she located a patient who was not too sick to submit to my ministrations of mercy.

As I stood there, mentally reviewing the proper technique of wrapping the washcloth around my hand, in you dashed — ob-

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sciatica

Analgesics alone merely mask pain. New Medaprin adds Medrol* to suppress the inflammation that causes the pain and stiffness.

Thus, to the direct relief of musculoskeletal pain,

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viously in search of something you needed stat!

You glanced toward the corner I occupied and said, "Where can I find a sterile #20 needle in this place?" In answer you got:

"Ah . . . um . . . uh . . . uh . . . I don't know, Doctor."

This wasn't the *whole* truth.

Not only did I not know *where* but I also didn't know *what* a sterile #20 needle was.

Dazed

You couldn't know I had never been in a hospital before, and certainly I couldn't admit it to you. As you hurriedly departed, I got the distinct impression from your scowl: "They're getting more stupid every day, these student nurses."

Even so, I was dazed by your magnificence. There was something so appealing, so heroic about you in your starched, spotless white trousers and intern's jacket. You were all Men of Medicine personified, to me.

Oh, I was stricken. The disease is known as Hero Worship—and it took two full years for the fever to run its course.

It may surprise even you to learn that never once in that length of time did you make an error; your diagnostic ability was remarkable; you were the healer

of all mankind. (Only later did I discover you thought so, too!)

Young

It could have been only a very young, very naive student nurse who would believe so wholeheartedly as did I in the Infallibility of the Physician.

It was inevitable too, that a dreadful day of disillusionment would arrive. And, it came.

Perhaps you do remember this occasion. We had a slight romantic interest in each other then . . . I was a senior student nurse and you had just begun your internship. It was the first time our ward rotation had coincided, and never had I been so eager to go to work each morning.

To watch for your appearance. stethoscope dangling from your pocket, to gather your charts and follow you down the long hall on rounds, to carry out your orders: "Yes, Doctor." "Certainly, Doctor." "Right away, Doctor."

I was living my Nightingale Pledge ". . . to aid the physician in his work. . . ."

We stopped to check newly admitted Mrs. Parker, unconscious, somewhat cyanotic, not yet diagnosed. You decided she needed immediate oxygen by nasal catheter. Pete, the orderly, wheeled in a tank as I opened

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A COMPLETE CHOICE



about the author

After completing her nurse's training at a medical center in the Southwest, the author did general and office nursing. This was followed by four years of O.R. nursing at a large hospital in Texas.

the tray containing the catheter, lubricant and adhesive tape. I handed you the catheter and watched in astonishment as you pushed it into her nose until only an inch or so remained visible! There you taped it and turned the gauge to five liters per minute. A page from my nursing procedure sprang before my eyes in capital letters: TO ADMINISTER OXYGEN BY NASAL CATHETER, INSERT THE CATHETER NO MORE THAN ONE OR TWO INCHES INSIDE THE NOSE.

What shall I do, I wondered frantically? He's a doctor; he knows what he's doing; he can't be wrong. There must be a reason he inserted the catheter so far, but what could it be? Where did it go? Trachea? Esophagus? Curled up inside her mouth?

Human beings

I didn't follow you from the room just then. I had to have time to think and to observe whether this was right or wrong. It wasn't long until I knew . . . the unmistakable signs of an en-

larging abdomen told me. I didn't go to get you but instead pulled the catheter out and reinserted it an inch.

Mrs. Parker wasn't harmed, but my whole world had come crashing down around me. Forcibly it had hit me: physicians are human beings, not gods to be worshipped! So this is what it means ". . . with loyalty will I endeavor to aid the physician in his work. . . ." Not necessarily to follow you blindly but to recognize the possibility of human error, be observant, and exercise my own knowledge when necessary to help you heal the sick; to give you the benefit of whatever practicalities I learned that you might not have been taught. I tried to make it tactful when later I gave you private instructions in the technique of administering nasal oxygen, and you seemed genuinely appreciative. It was only the first lesson of many to come.

The years passed . . . your pedestal disappeared as I climbed up on one . . . you seemed less and less intelligent as my knowl-



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edge grew by leaps and bounds . . . and a day arrived when I knew far more than you did!

From my perch as head nurse in surgery, I looked down upon you, poor fellow. New intern, first day to scrub in surgery. Look at him; he doesn't even know how to get into a pair of gloves without contaminating them! Medical schools must be lowering their standards these days.

As you can see, as I became "senior," our roles were reversed.

I hereby apologize for I must have been obnoxious in my state of superiority.

More years

More years passed . . . and with their passing came more maturity and the rebirth of humility, which comes out of the experience of living.

Now neither of us occupies a pedestal; we meet on common ground.

We each have a background of knowledge and experience which, when used properly, combines to make us both more valuable.

Our patients need both of us working together, side by side,

in mutual respect and understanding.

What are the problems nurses and physicians have in their relationship? How can they be solved? Every situation, each doctor and each nurse is unique. The ills that are present in the physician-nurse relationship today are no more and no less, I suspect, than those that beset the whole human race. Both entities could be cured with a universal panacea prescription: Put yourself in the other fellow's place. Then, selfishness goes. Instead of anger and bitterness come tolerance and understanding.

The next time I am tempted to read you the riot act because you haven't written your history and physical before the patient comes to surgery, I'll try to remember you were up all night assisting on that critical gun-shot wound. I'll hold my temper and put a little understanding into our relationship.

And the next time you feel justified in loudly berating a poor student nurse, remember . . . it wasn't so long ago that you were learning your way around a ward. I know, doctor. I saw you.

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Is a few weeks spent at a summer camp as camp physician a carefree reprieve from professional responsibility? Not by a longshot. In fact, such an assignment might favor more toil than free time. But, you'll be almost guaranteed less tension and far more relaxation than is possible during a comparable period spent in your hospital training.

Shorts

As camp doctor, you will face all problems of modern youth from bed wetting in the very young to broken hearts among teenagers. You may also find yourself with a small adult practice which might include indiges-

tion among the kitchen help and hypertensive headaches, popular among directors.

But the happy note to remember is whether treating a laceration, athlete's foot, or mumps, you will be wearing shorts. And though dispensing the same brands and shots you handle in your hospital, you'll be in an airy infirmary. This is camping—and it is healthful, rejuvenating and lots of fun.

Definitive treatment pertinent to fractures, snakebite, suturing, unresolved fevers and illnesses is not intended in a camp infirmary, and logically, is transferred to the town physician. (Nearly all camps provide broad medical-

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Tenure, salary

Many camps will accept your tenure for as little as two to four weeks, and might also house your wife and children as part of your salary.

What salary to ask? Well, you'll never receive what you'd earn in private practice! Since the camp nurse receives \$50-\$75 per week, the author (who has had 4 "summers" of camp "doctoring," each summer being 4 weeks only) is of the opinion that a fair salary should be not less than three times the nurse's stipend. Camps sponsored by charitable organizations offer much less.

How to get started? First watch the want ads in the larger newspapers. Make your contact early. (RESIDENT PHYSICIAN carries summer camp classified ads. See page 200.)

Camp directors complete their choices as early as they can, propagandizing them in glowing letters and announcements which are sent to their prospective clientele.

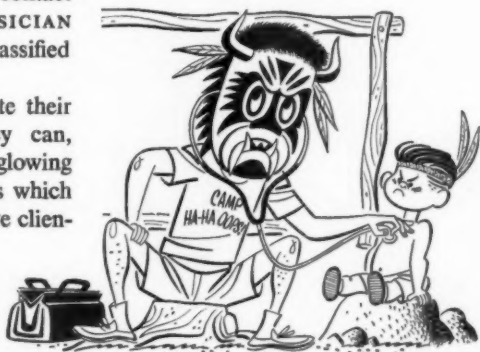
The American Camping Association, Inc. of Bradford Woods, Mar-

tinsville, Indiana, is the information center for every camping need. Their publication, "Directory of A.C.A. Member Camps" (50c) lists a brief description of the several hundred approved camps in the U. S., and as far as Canada, Alaska, and Hawaii. This includes the major camp activities, population, age groups, and key personnel.

The monthly publication of the A.C.A. is "Camping Magazine" which is included with the \$10 annual membership. Camp positions are advertised in each issue.

If your local library does not have this publication, it may be purchased from the publisher, Howard Galloway, 120 West Seventh Street, Plainfield, New Jersey.

The A.C.A. also lists camp staff placement services in vari-



ous sections of the U. S. to which one may apply. These services are, in nearly every case, free. (Listing on page 146.)

Younger

Even if it may prove to be a "quasi" vacation, you'll be tanner and healthier when you come home. Somehow, when the first signs of spring appear each year, I begin to look forward to renewing acquaintances with those pestering, sniffing rock-'n-rollers! I think you will, too.

You will look back on the lec-

tures in accident prevention and hygiene you extemporized, the phone calls from frantic parents, several hundred miles away, the participation in the camp sing, orchestra, dramatics, or in the teaching program of the camp. You will recall your cautious moments on the tennis courts, in a canoe, or in the swimming hole.

And you're sure to find out how really "tired-blooded" those sedentary muscles have become!

But you will come home brighter and younger because you were with the young.



"It'll make the other multiple vitamin capsules look sick."

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How to Avoid a Breach of Contract

If the physician is not careful to distinguish between reassurances to ease a patient's mind and promises or guarantees of success, he may face a suit for breach of contract.

George A. Friedman, M.D., LL.M.



Though claims against doctors for breach of contract are not as numerous as malpractice actions, their occurrence is by no means insignificant.

And they are a lot easier to prove.

A malpractice action is based on negligence, and in most instances expert testimony—hard to come by—is essential to prove that negligence.

But negligence is not involved in a breach of contract action. A jury hearing this type of case must be satisfied on these three major points:

- Did the doctor make a promise?
- Was there a consideration for the promise?
- Did the doctor fail to perform?

As negligence is not involved, a physician who uses his utmost skill is as open to damages as the one who is careless, *if his performance falls below his promises.*

This promise does not have to be made in writing. The doctor who casually reassures a worried patient that after the operation "he'll be as good as new" may

Lifts depression...as



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed — often in two or three days. She eats well, sleeps well and soon returns to her normal activities.

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...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

balances the mood—no “seesaw” effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient—they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation—they often deepen depression.

In contrast to such “seesaw” effects, Deprol lifts depression as it calms anxiety—both at the same time.

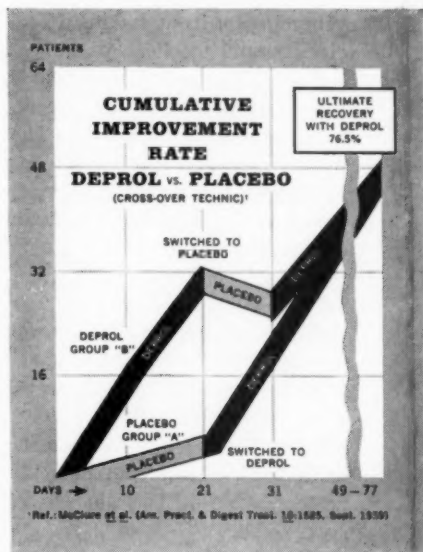
It acts swiftly—the patient often feels better, sleeps better, within one or three days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly—often within two or three days.

It acts safely—no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Deprol[▲]



WALLACE LABORATORIES / New Brunswick, N. J.



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

later find himself sued on just that statement.

Contracts

One of the maxims of malpractice law is that the doctor does not guarantee a cure or warrant that his treatment will be successful. But there is nothing *except his common sense* to prevent a doctor from making a special contract to effect a cure.

Some years ago it was argued that such a contract was invalid, being against public policy. The reason suggested was that the enforcement of contracts to cure would dissuade physicians from encouraging patients and giving them hope (perhaps an important aid to their recovery) in the fear that these words would be taken as a promise.

A New Hampshire court struck down this argument in 1932, pointing out that it was a simple matter for a doctor to make it definite that he guarantees no good result.

Promise

Doctor diagnosed plaintiff's trouble as a diseased appendix. Plaintiff indicated he thought he had gallstones. Doctor said: "I will remove the gallstones, the appendix . . . I will remove all causes of your disease, and I will

certainly guarantee to turn you out a new man within two or three weeks."

The appendix was removed, but plaintiff's symptoms remained the same. Two months later another physician removed a gallstone. Plaintiff recovered damages for breach of contract.¹

Liable

In a New York case the court said: "If the doctor makes a contract to effect a cure and fails to do so, he is liable for breach of contract even though he uses the highest possible professional skill."

This, of course, eliminates the burdensome problem of proof of negligence. In another New York case a dental surgeon extracted four teeth from plaintiff, and in the process a gold inlay became detached from one tooth and lodged in plaintiff's throat. Proving negligence, if indeed any existed, would have been difficult.

Plaintiff alleged a contract "to extract the teeth and each and every part thereof from within the plaintiff's body." The breach claimed was the failure to remove the gold filling from plaintiff's body. No negligence was alleged.

The court sent the case to the jury on the issue of the existence

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of the contract. If it existed the defendant would be liable on his contract regardless of the degree of care exercised.²

Patient was infected with syphilis. Defendant contracted to cure her of this disease. Death followed immediately upon the giving of neosalvarsan in the course of treatment.

The court held that if the jury believed there was such a contract, the death itself would be a breach of the agreement, and no question of negligent conduct on the part of the defendant was relevant to the issue.³

Consideration

Every contract and every physician's guarantee that an operation will be successful must be supported by a consideration, i.e., either payment or a promise to pay, or some other benefit. But past considerations will not support a subsequent promise.

Plaintiff injured the thumb of his left hand, causing the first joint of the thumb to become stiff. Some six weeks later he asked the defendant what caused the stiffness. Defendant replied that the tendons had been severed, but that the condition could be remedied by a simple operation costing from \$25 to \$50.

Plaintiff agreed to the operation,

whereupon defendant remarked, "I'll guarantee your hand will be 100 percent efficient after the operation."

The court held that this was a gratuitous remark, not supported by any consideration. "What was the consideration for the guaranty? What was the benefit to be received by the defendant for the warranty? The only consideration or benefit for this whole transaction was the fee of from \$25 to \$50 for the operation."

A verdict of \$5000 for plaintiff was set aside and judgment entered for defendant.⁴

Statutes

Another reason for suing for breach of contract rather than for malpractice is the longer statute of limitations applicable to a contract action. In many jurisdictions a six-year limitations period is provided for contracts, while the malpractice statutes run after one or two years.

Plaintiff alleged that defendant contracted to perform a minor operation, removal of a growth by fulguration, a procedure which would not involve incision through the abdominal wall; to do the job in "a good workmanlike manner," and "to cure" him in "one or two days."

Instead defendant punctured an organ, necessitating a major operation and hospitalization for a month. Plaintiff sued after the malpractice, but before the contract statute of limitations had run. The court upheld the action, stating that a doctor and his patient are at liberty to contract for a particular result and if this result is not attained, a cause of action for breach of contract results which is entirely separate from one for malpractice.⁵

Two cracks

There is a third reason for a plaintiff to elect to sue on a contract rather than for malpractice. Suppose he has sued for malpractice and lost because he couldn't prove negligence. In some jurisdictions, such as New York and New Hampshire, if he can make out a contract, he can start a second suit. In effect he gets two cracks at the nut.

In Massachusetts, on the other hand, the contract suit is barred if judgment has previously gone against plaintiff in a malpractice suit arising out of the same set of facts.

Decisions in New York and New Hampshire hold that malpractice and contract actions do not bar each other because they require different facts, different

proof, and result in different damages.

Damages

The measure of damages in a contract case is to put the plaintiff in as good a position as he would have been had the contract not been breached. Compensation is given for only those injuries which were reasonably foreseeable as a probable result of the breach when the contract was made.

One of the maxims in the field of contracts is that no damages are awarded *for pain and suffering*. Recovery in a contract case normally was limited to consequential medical and convalescent expenditures, loss of wages, loss of consortium, and perhaps other related losses directly traceable to the breach.

Normally in malpractice cases damages are allowed for physical pain, mental suffering, and impaired earning power.

There have been breach of contract cases, however, in which damages were awarded for pain and suffering by tortuous reasoning of the court. In a 1915 Mississippi case a physician who had contracted to attend plaintiff during her confinement and failed to do so was liable for the pain and suffering resulting therefrom.⁶

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The physician's plea that he couldn't leave another patient was no defense.

The same result held in a case where a defendant failed to provide hospital services for plaintiff; where a private hospital exposed plaintiff's wife to the outdoors so that she died; and where defendant failed to provide medical care and attention to employee's child, contrary to agreement. In all these cases the court held that pain and suffering were fairly within the contemplation of the parties when the contract was made.

The more recent case (1957) of *Stewart v. Rudner*⁷ upheld the right of a woman whose child was

stillborn to recover damages for mental suffering in the amount of \$5,000.

Plaintiff a woman of 37, was married to a man of 63. She had two stillbirths previous to this conception, and she and her husband were both fearful of another stillbirth. The situation was explained to defendant who agreed to perform a Cesarean. The couple believed the fetus had come to full term in July. But in visits made in August the defendant said "everything was normal and in good condition," and sent them away.

On September 4 labor pains commenced and persisted. The doctor sent plaintiff home instead

NEWS ROUNDS

Research Aimed At Mongolism

Pamphlet Tells Story. A program of medical research is being aimed at mongolism, a form of mental retardation which afflicts more than 35,000 infants born in the United States each year, according to the U.S. Public Health Service. "Mongolism—Hope through Research," a pamphlet published by PHS, tells of the broad research efforts underway at the Service's National Institutes of Health to find the cause of the disorder. Single free copies of the pamphlet may be obtained by writing the National Institute of Neurological Diseases and Blindness, Bethesda 14, Maryland.

of to surgery. On September 5 plaintiff was delivered by an episiotomy. The child was dead.

The court held that there is a marked trend toward recovery for mental disturbance in contracts as well as malpractice actions, and that emotional damage is just as real and compensable as physical damage.

The court however warned that "the doctor's therapeutic reassurance that his patient will be all right, not to worry, must not be converted into a binding promise by the disappointed or quarrelsome."

A court will not aid an illegal contract. A doctor who contracts to perform an abortion, for example, can not later be sued on his failure to perform; nor can he sue for the fee agreed upon.

Sterilization contracts

A recent Pennsylvania case⁸ examined the public policy on sterilization, and came up with a curious result. Plaintiff, the father of four children, contracted with the defendant for a vasectomy because he couldn't afford to support a larger family.

After the operation his wife gave birth. Plaintiff sued the doctor for breach of the contract to make plaintiff "immediately and permanently sterile and guaran-

teed the results thereof." The damages he sought were for the expense of rearing and educating the child. The court held:

- a doctor and his patient can contract for the particular results of an operation.

- a contract to sterilize is not against public policy—but public policy forbade recovery of the damages sought.

While it is possible that damages would be recoverable for hospital and other allied expenses on such a contract a test case hasn't yet arisen.

Insurance

Are breach of contract cases covered by malpractice insurance? New York has answered this question in the negative, the state of Washington in the affirmative.

In the New York case patient sued physician for \$15,000 for breach of contract. Patient alleged physician had agreed to "remove certain markings from the patient's face and restore it to normal in consideration of \$100." After several operations the abnormality was worse. The jury brought in a verdict of \$4000.

A new trial was ordered by the court on technical errors, and the case was then settled for \$1250.

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The physician then sued the insurance company for that amount plus \$2000 counsel fees and costs.

He lost the case. Insurance coverage for claims arising out of "malpractice, error or mistake" is clearly legally distinguishable from coverage for breach of contract.⁹

On an indemnity clause almost identical with the one in the New York case a Washington court reached the opposite conclusion.¹⁰ The facts of this case arose out of *Schuster v. Sutherland*, discussed previously, wherein a patient recovered \$2,466.15 from a doctor on a breach of contract suit for failure of the doctor to remove a gallstone. The doctor thereupon sued the insur-

ance company and recovered. The court said:

"The words 'malpractice,' 'error' and 'mistake' as used in this indemnity policy do not mean necessarily the same thing. If they were so intended, it was an idle thing to insert more than the word 'malpractice.' A physician may err or make a mistake, without being guilty of malpractice. This policy covers malpractice. It covers error and it covers mistake in the practice of appellant's profession; and if liability flows from either, and he is required to pay damages on that account, we think it is plain that the policy here undertook to insure against such mistake or such error as well as against malpractice."

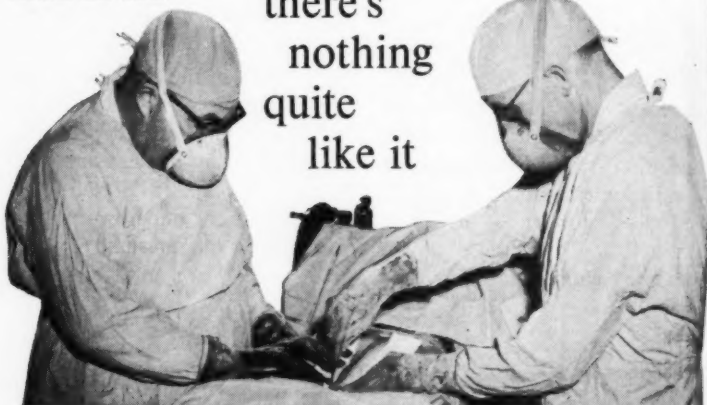
References

1. *Schuster v. Sutherland*, 158 P. 730 (Wash., 1916).
2. *Keating v. Perkins*, 293 N.Y.S. 197 (1937).
3. *Giambozi v. Peters*, 16 A. 2d 833 (Conn., 1940).
4. *Wilson v. Blair*, 211 P. 289 (Mont., 1922).
5. *Robins v. Finestone*, 127 N.E. 2d 330 (N. Y., 1955).
6. *Hood v. Moffett*, 69 So. 664.
7. 84 N.W. 2d 816 (Michigan).
8. *Shaheen v. Knight*, 11 D. & C. 2d 41 (Lycoming, 1957).
9. *Safian v. Aetna Life Ins. Co.*, supra, footnote 4.
10. *Sutherland v. Fidelity & Casualty Co. of NY*, 175 P. 187 (1918).

Whatever the procedure

a truly sterile operative field can be maintained by this new skin draping technic. Regardless of anatomic location, contour, or intricacy—Vi-Drape® Film isolates the wound from the patient's own skin bacteria. Vi-Drape Film is a soft, pliant transparent plastic sheet which is adhered intimately and firmly to the surgically prepared skin of the operative field with Vi-Hesive® Adherent. Incision is then made right through the plastic skin drape so that protection is complete to the incisional edge. It will not come loose to permit accidental contamination even during lengthy, complicated procedures. Vi-Drape Film eliminates the need for interfering skin towels and clips, and thus affords clear visibility of the entire operating field as well as easier approach. It is impermeable to bacteria and fluids.

there's
nothing
quite
like it



Incise right through the Vi-Drape Film. Wider field of visibility facilitates identification of landmarks. Extensive sterile field is maintained for second incisions or double approach. For example—in bilateral herniorrhaphy incisions, the large linen drape can be shifted without fear of contamination. In inguinal hernia and orchidopexy, the scrotum remains visible and accessible

for palpation, and at the same time is completely sealed out of the operative field. In aortal femoral bypass procedures, Vi-Drape Film applied extensively can achieve a degree of asepsis previously considered impossible, since it allows access to a sterile abdominal field as well as in both femoral canals simultaneously, without danger of contamination from the perineal area.

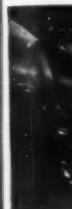


At closure suturing is completed to skin level, then the transparent film is peeled back from wound edges, and skin suturing completed before the entire drape is peeled off. Some surgeons prefer to suture right through the film, leaving a small piece intact under the sutures. Following either method, Aeroplast® Surgical Dressing can be sprayed on as the definitive dressing. It forms a tough but flexible plastic film dressing impermeable to environmental contamination and requiring infrequent changes.

Photos at left and above courtesy Ralph Adams, M.D., Boston, Mass. and Wolfeboro, N. H.



Basic technique for freshly "prepped" dry, Vi-Hesive in sprayed of pink tint from distance. S. Drape Film over proposed areas then molded by and wide area. Photo Adams, M.D.



Visibility of previously are particularly surgery. Ill laminectomy

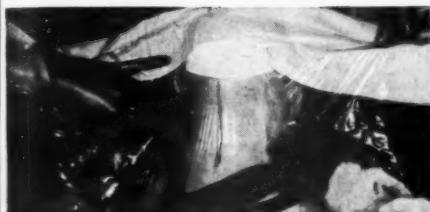


Large areas for thoracic surgery. Landmark shoulders isolated from cleaner, d is possible drapes. Surgical postoperative of healing without re Photo courtesy Jackson, Minn.



Basic technique When freshly "prepped" skin is dry, Vi-Hesive Adherent is sprayed on to an even pink tint from about 12" distance. Sterilized Vi-Drape Film is held taut over proposed operative area then smoothly molded by hand to site and wide adjacent skin area. Photo courtesy Ralph Adams, M.D.

Sealing off the contaminated colostomy or ileostomy, and yet having it visible while exploring a new operative field, is made possible by the application of Vi-Drape Film to the entire area. Photo courtesy of Robert M. Zollinger, M.D., William G. Pace, M.D. and Marjorie N. Reed, R.N., Columbus, Ohio

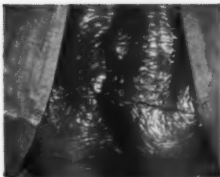


Visibility of landmarks, maintenance of asepsis in operative areas previously hard-to-drape, and isolation of the entire operative zone are particular surgical advantages of using Vi-Drape Film in neurosurgery. Illustrative is the draping of the cervical occipital area for laminectomy shown above. Photo courtesy Arthur B. Eisenbrey, M.D., Detroit, Mich.



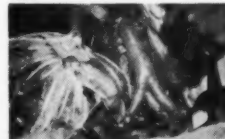
Smooth molding and close adherence of the plastic skin drape to the difficult contour of the hip, provides an aseptic operative area previously considered almost impossible to achieve. Vi-Drape Film clings closely to the skin throughout long procedures. Photo courtesy Chas. G. Lovingood, M.D., Frank L. Shively, Jr., M.D. and Albert M. Storrs, M.D., Dayton, Ohio

Large areas can be sealed off for thoracic or cardiovascular surgery without hiding landmarks. Neck and shoulders are completely isolated from the incision. A cleaner, drier operative field is possible using plastic skin drapes. When Aeroplast Surgical Dressing is used postoperatively, evaluation of healing can be made without removing dressings. Photo courtesy Curtis P. Ariz, M.D., Jackson, Miss.



Isolation of the anal area from the vaginal orifice during correction of prolapse of the vaginal vault avoids contamination by fecal extrusions.

Exteriored vaginal vault is protected from contamination by plastic drape clinging closely to vaginal orifice during procedure and by isolation of the anus. Photos courtesy C. Paul Hodgkinson, M.D., Detroit, Mich.



To prevent trauma, desiccation and infection — Vi-Drape Film is frequently used as a protective wrap for exposed organs as shown above holding intestines during an aortic graft. Photo courtesy Chas. G. Lovingood, M.D., Frank L. Shively, Jr., M.D. and Albert M. Storrs, M.D., Dayton, Ohio

Would you like to see a full-color sound motion picture further illustrating the application of Vi-Drape Film in varied surgical procedures? The film, "A New Transparent Plastic Surgical Drape," produced by Robert M. Zollinger, M.D., William G. Pace, M.D. and Marjorie J. Reed, R.N., at Ohio State University Department of Surgery, is available for showing to all members of the surgical team.

Please send requests to: AEROPLAST CORPORATION Station A—Box 1, Dayton 3, Ohio

Vi-Drape® Film, Vi-Hesive® Adherent-Pats. Pend. Aeroplast® Dressing-U.S. Pat. No. 2,804,073 All photos shown are of actual procedures.

When You Meet the Press

To promote a greater and smoother flow of accurate medical news from the medical profession and hospitals, a number of state medical groups have prepared guide booklets on media relations. Here's one such guide, designed to assist physicians, county societies and local hospitals cooperate with the media of public information in the community.

Within the framework of this guide, county medical societies and local hospitals may wish to adjust certain provisions to facilitate cooperation with the media of public information in their own communities. It is with this understanding in mind, that the following considerations are given.

This article is reprinted from a booklet prepared and published by the Medical Society of the State of New York. It is designed to assist members in their relations with representatives of the various media of public information. The section on hospitals was prepared and approved by the Hospital Association of the State of New York and the Greater New York Hospital Association.

PHYSICIANS

1. The officers, committee chairmen or designated spokesmen of the medical society in the State of New York shall be available at all times to the press, radio and television in order that authentic information on medical subjects can be obtained as promptly as possible. The Department of Communications of the Medical Society of the State of New York is available to representatives of all media of public information to assist them in any way possible. Medical societies shall urge all doctors who be-

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come aware of new developments in the field of medical science to make such facts available for public information, through proper officials of their county or state medical society.

2. Editorial executives of newspapers, radio and television stations, and magazine editors and writers frequently find it necessary to obtain information for dissemination to their readers or listeners. To facilitate obtaining of such information, the medical societies may furnish them with a list of physicians from whom authoritative information may be obtained. Every effort should be made to supply the names of physicians qualified to speak in their respective fields.

3. These spokesmen may be quoted by name and title. *This should not be considered by their colleagues as seeking self-publicity*, since it is done in the best interests of the public and the profession.

4. Doctors of medicine, other than officially designated spokesmen, when approached by representatives of newspapers, radio and television, and science or magazine writers for information relating to scientific subjects are urged to comply with such requests. In cases where premature release of scientific information

THE PRIMARY RESPONSIBILITY OF THE DOCTOR AND THE HOSPITAL IS THE WELFARE OF THE PATIENT. YET, IT MUST BE RECOGNIZED THAT THE MEDIA OF PUBLIC INFORMATION EXIST FOR THE COMMON GOOD, BRINGING MATTERS OF GENERAL INTEREST TO THE PUBLIC QUICKLY AND CORRECTLY.

is a concern, a frank discussion of the problem is suggested between the doctor and the press representative.

5. Publications of photographs of speakers who appear before recognized medical organizations, either in the official program of the scientific meeting or in the public press in connection with such meeting, shall be acceptable. The use of photographs in the press when physicians are elected to office or when physicians are quoted by name on matters of general interest, not related to the care of a specific patient, is likewise acceptable. Photographs of physicians in general or society news, not related to medical news or the care of patients, shall

be acceptable unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society.

6. At all times the doctor of medicine is expected to comply with the Principles of Professional Conduct. It shall be the responsibility of the Board of Censors of each county society to see that these principles are not violated.

7. Doctors of medicine are compelled to protect the inalienable rights of the personal privacy and legal rights of patients. The doctor-patient relationship with its confidential communications must be maintained. The physician must safeguard his own right of privacy to avoid legal retaliation. With these considerations in mind the physician should assist the representatives of these media in every way possible.

8. When information concerning a specific patient is requested, the physician should obtain the consent of the patient before releasing such knowledge. The patient's decision is final under the law. A physician may encourage the patient or his family to state the cause of illness, or the cause of death, when this information

is requested by a bona-fide representative of the press. Where a person of public interest is involved, the physician should arrange for regular bulletins concerning the personage. The ethical physician will use good judgment regarding the use of his name in connection with such published reports.

9. For purposes of clarity the medical society outlines the following principles to guide physicians who appear on TV or radio programs or in other media of public information, such as newspapers and magazines:

- Doctors of medicine are expected to refrain from sponsoring products directly or by implication that are not accepted by the medical profession: i.e., patent medicines.

- When introduced as a doctor on TV or radio programs, pictured in an advertisement or quoted as a physician in a newspaper or magazine article, such individual cannot escape the implication of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

- Sound judgment, good common sense and adherence to the Principles of Professional Conduct are expected of any physi-

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cian when appearing on TV or radio programs, or in other media of public information, such as newspapers and magazines, in whatsoever capacity. It is the responsibility of the county society Board of Censors to discipline its own members who violate these fundamental qualities.

HOSPITALS

1. General principles and procedure:

- Each hospital shall have available at all times an authorized spokesman to answer inquiries from public information media.

- The names of the designated persons, telephone numbers and hours when available, should be made known to the telephone operators, admitting departments, information desks, nursing supervisors, emergency departments and others who are likely to receive calls from newspapers or reporters.

- Similarly, the names, telephone numbers and hours when available of these spokesmen should be filed with the press, radio and television.

- Information shall be provided to news agencies as rapidly

as possible without interfering with the health, privacy or legal rights of the patient or jeopardizing the hospital-patient relationship.

- Information relative to the activities of the hospital should not be designed to secure comparative advantage over other hospitals or personal advancement of any individual.

- Information relative to research and scientific projects should not be made without the consent of the individual or individuals and the sponsoring agency involved nor in any manner to conflict with the ethics of the professional group concerned.

2. Information to be given to news agencies:

- Hospitals shall give the name of the attending doctor when so requested by the media unless such physician in advance requests that he not be identified.

- When newspapers request the photographing of a patient in the hospital, such permission shall be given in the discretion of the administration, if the patient consents and if the attending doctor decides the patient's condition or interests will not be jeopardized. If the patient is a minor, permission of parents or guardian must be obtained unless the minor is "emancipated."

If the minor is of sufficient maturity, his consent should also be secured. No pictures will be permitted of unconscious patients or patients suffering from severe facial injuries.

- The death of a patient is presumed to be a matter of public record, and shall be reported by the hospital without the diagnosis or cause of death.

- Hospitals may give information concerning births in accordance with local practice.

- The admission of a patient may be acknowledged and the general condition stated.

- Emergency cases. Hospital may give name, age, address, occupation, sex, nature of accident—such as automobile, explosion, shooting; general extent of injuries—such as injury to leg, arm, etc.; burns, wounds and part of body. A definite diagnosis or prognosis should not be expressed.

- In cases of poisoning, stabbing, attempted suicide or other similar occurrences, no motives or opinions of motives should be given. Attempted suicide should not be characterized as such.

- No statement should be made as to whether a patient is intoxicated.

- If a patient is unconscious when he is brought to the hos-

pital, a statement of that fact may be made without indicating the cause of the unconsciousness.

PRESS, RADIO, TV

1. Representatives of the media of information recognize that the first obligation of the doctor and the hospital is to safeguard the life, health and legal rights of the patient. Conversely, the doctor should be aware of the existence of the "Canons of Journalism," and of television and radio codes under which all responsible members of such media function. Within the framework of this guide and the medical profession's Code of Ethics, physicians are urged to be less reluctant to discuss problems with representatives from any branch of the media of public information.

2. It is desired that the media of information know that the medical profession and hospital associations prefer no publication, broadcast or telecast of information designed solely to exploit the patient, the hospital or the doctor.

3. When official medical society spokesmen are available, it is suggested that on medical news a check for local tie-in will be

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considered before proceeding to local broadcast, telecast or publication.

4. It is desirable for representatives of the media of public in-

formation to understand why there are limitations placed upon the doctor of medicine and the hospital with regard to the release of information.

Acknowledgement

The fact that our guide has reached its third printing is one measure of its success in providing the framework for successful relations between representatives of the news media and physicians and hospitals. To Dr. John C. McClintock, past president of the Subcommittee on Cooperation with Media of Information, New York State Medical Society Committee on Public Relations; Dr. George

A. Burgin, present chairman of the subcommittee; Dr. John D. Naples, Dr. C. Stewart Wallace, and to all those who gave their time and effort to the development of the guide, our sincere thanks are gratefully expressed.

HENRY I. FINEBERG, M.D.
President,
Medical Society
of the State of New York

NEWS ROUNDS

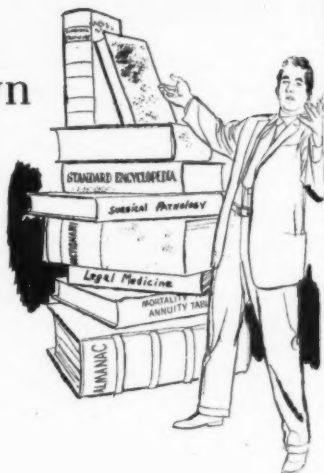
Medical School in Arizona?

Study of Needs Begins—Arizona has taken the first step in determining whether a medical school is needed in the state. With a \$135,000 grant from the Commonwealth Fund of New York, the Arizona Board of Regents has appointed Dr. Joseph F. Volker, presently director of research and graduate study of the University of Alabama Medical Center, to head a survey of the medical, economic, educational and other facts of Arizona life. Dr. Volker's group is expected to complete its report and recommendations by July of next year.

The Doctor's Own Medical Library

Saul A. Kuchinsky

A librarian gives you some tips on building your personal library, discusses binding, indexing and filing.



Closer to the doctor than any other instruments of his profession are his books. They first introduce him to medicine and then give him life-long instruction in making it a going concern.

No doctor can be without his own medical library, whether it is simply a pile of books in a corner, a few shelves, a complete room or an entire house.

Some doctors are life-long bibliophiles, lovers of books. They collect medical books from pre-med days through retirement, for love of the profession, for love of the written word. When, at death,

their wills convey their libraries to school or hospital, they have truly given of themselves.

Comfort and light

There is little to be said of the physical library except in general terms. You should have at least one comfortable reading chair and desk. You must have good lighting that illumines your reading and makes it possible, too, for you to see the titles on the highest shelf. And most important, you do need adequate shelf space.

Other points:

when anxiety
accompanies
somatic
complaints



STELAZINE[®]

brand of trifluoperazine

*the outstanding tranquilizer that relieves
anxiety and restores normal drive*

When 'Stelazine' was given, along with appropriate specific medication, "marked relief of emotional and physical symptoms was obtained in 82% of the [120] patients studied.

"Outstanding results were obtained in the patients with gastrointestinal symptoms. . . . In depressed patients, there was a notable restoration of energy and drive, without euphoria."

Phillips, F. J., and Shoemaker, D.M.: Treatment of Psychosomatic Disorders in General Practice, Report accompanying Scientific Exhibit at the 12th Clinical Meeting of the American Medical Association, Minneapolis, Minnesota, Dec. 2-5, 1958.

AVAILABLE—For use in everyday practice, 1 mg. tablets, in bottles of 50 and 500; and 2 mg. tablets, in bottles of 50. **STARTING DOSAGE**—One 1 mg. tablet, b.i.d. (morning and night). Additional information on request from Smith Kline & French Laboratories, Phila. 1, Pa.

SMITH
KLINE &

- Journal subscriptions shelve generally at two volumes a year.

- Space must be made for a hard core of at least one hundred texts and room to grow.

A separate fixture for a multi-volume, loose-leaf medical "system," plus dictionaries, directories, various reference works and perhaps a geographical globe or busts and portraits of historical medical figures fill out the picture.

Journals

Each journal volume has its own index. This is normally contained within the last issue of the volume, or when separate, may be distributed at the same time with it. There are exceptions. Such journals as *Lancet*, *British Medical Journal*, *Diabetes*, *Anesthesia* and *Analgesia*, *British Journal of Anesthesia* and *Public*

Health Reports, among others, publish their index months later.

You must have this index before you send your journals to the binder. He must have title page, table of contents and all issues. Remember, patients have been known to tear articles from the unbound journals that some doctors display in waiting rooms; also some journals occasionally contain gross printers' errors. So, check carefully before sending journals to the binder.

Binding

Also, inspect the bound volumes as soon as they are returned. Binders make mistakes. (They are responsible for them, of course.)

The binder should take no more than five weeks, charge from \$2.75-\$3.50 per volume. He picks up and delivers in quantity

About the Author

A graduate of New York University and Western Reserve University Library School, the author has been a school teacher, postal clerk, newspaper reporter and, since 1948, professional librarian. He was circulation librarian at the Union Theological Seminary (Protestant) from 1950 to 1953, organized or reorganized six Jewish Center libraries in New York from 1951 to 1956. Medical librarian of the Jewish Hospital of Brooklyn from 1953-1959, he is presently librarian at Montefiore Hospital Library, Manhattan. Mr. Kuchinsky has examined 21 hospital medical libraries in New York and some 50 university and public libraries from coast to coast.

but may ask for use of your hospital as a way-station for only a few volumes.

In the matter of color of binding, you'll have dozens of choices. However, first get the binder's assurance that his interesting chartreuse is a staple stock number and not one that will be discarded next year in favor of a new shade of pink.

The spine of the journal volume carries title, volume number, months (when multi-volumed within the year) and year. The doctor's name is stamped on the bottom of the spine or the front cover or not at all. It is either Dr. John Doe or John Doe, M.D. All this must be clearly explained to the binder in advance and preferably in writing. Finally, bound volumes are not to be cleaned

with a damp rag unless you want the thin veneer of shellac, often used to protect the buckram covers, to streak white.

Indexes

For bibliographic searching of the journal literature, purchase is imperative of at least the journal index called Current List of Medical Literature.¹ This is the most current of the indexes, appears monthly in soft covers, binds twice a year.

For the back years an easier index to use is Quarterly Cumulative Index Medicus,² appearing twice a year in hard covers and, unfortunately, three years behind.

Only bibliophiles will want the giant 58-volume Index-Catalog of the Surgeon-General's Office,³ out-of-print, expensive, many

NEWS ROUNDS

All Help Design Hospital

Hospital Planning—Considered a unique development in hospital design, the recently completed \$4.5 million Women and Children's Hospital of Baylor University Medical Center, was a product of months of consultation between architect and doctors, nurses, administration, plus advisory committees of former hospital patients whose ideas were incorporated into the modern building.

years behind but containing a mine of valuable older material.

Texts

The third and most important section of your library comprises the texts. Here are multiple choices and problems. After a basic collection is bought, the problem of which titles to buy in new editions and which to drop in favor of new titles is a continuing one. Texts tend to be concentrated in your specialty. Yet, you should periodically review your collection to see that it has scope as well as currency.

The prime sources of price-lists for the text purchaser remain the publishers' catalogs, periodically distributed descriptive literature and ads in the journals. Journal book reviews are used as a qualitative measure as well as "on approval" borrowing from jobber or publisher. The Book Reviews of the Journal of A.M.A. and their listing in the index of each bound volume at the end of the B's are an excellent review source.

Professor Thomas P. Fleming,⁴ director of Columbia University's medical library, has written a fine book of medical bibliography, and librarians Janet Doe and Mary Louise Marshall⁵ are editors of a source book of

medical reference works that is a classic of its kind.

Among the very usable annual medical bibliographies is a good basic price list compiled by J. W. Stacey, Inc.,⁶ that most book jobbers hand out free. The 3-title compendium of the works of all publishers that began as Publishers' Trade List Annual⁷⁻⁹ and now, in toto, responds to searching by publisher, author, title and subject is a welcome, definitive bibliographical guide to non-medical as well as medical books, of particular value for the doctor who has both kinds of library.

File

If you're reprint-minded, you'll want a file cabinet for your collection. Pamphlets will interfile with the reprints. The subject-heading classification you use may be one you make up or one chosen from the headings used by some standard index such as Index Medicus.

It is imperative that you 1) mark each reprint along the top, plainly and on receipt, with the appropriate heading and 2) keep a card-file record of the subject-headings you use, lest you forget and employ a variant form in the future for the same subject.

As to miscellaneous problems, here are some observations:

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April

• Buying texts from a jobber rather than the many publishers eliminates multiple billings.

• Leather bindings are expensive and tend to crack.

• Books and journals should be rubber-stamped with the doctor's name to prevent loss. (A stock of humorous overdue notices might be printed up and

mailed to retrieve books from forgetful friends.)

Library supplies and furniture may be bought from Gaylord Bros. of Syracuse, N. Y., Remington Rand of N. Y. C. or Demco of Madison, Wisconsin. These firms fill needs in areas that the more general office supply houses don't handle.

References

1. Current List of Medical Literature. Washington, Vol. 1, 1941.

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4. Columbia University. School of Library Service. Guide to the literature of the medical sciences. N. Y., The School, 1953.

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6. J. W. Stacey, Inc. Medical books in print. San Francisco, 1958.

7. The Publishers' Trade List Annual. 2 Vol. N. Y., Bowker, annual in Sept. \$6.50.

8. Books in Print: an index to the P.T.L.A. (author-title) N. Y., Bowker, annual in Oct. \$19.

9. Subject Guide to Books in Print. N. Y., Bowker, Nov. 1957. \$17.50.

SUPPORT
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HEALTH
ASSOCIATION



AMERICAN CANCER SOCIETY

Spotlight on Cancer

Stressing early detection and treatment, the American Cancer Society, one of the nation's largest voluntary health agencies, has stepped up the community attack against cancer. Through detection clinics, tumor registries, educational programs, both lay and medical, and its support of research, ACS is expanding its services in the battle against this dread disease.

Beginning as the American Society for the Control of Cancer in 1913, it was founded in New York City by a group of dedicated citizens, ten physicians and five laymen. At that time, the public was uninformed about cancer and there were no programs in cancer research or cancer control, yet the disease was claiming 78,000 lives per year. There were only two specifically designated cancer hospitals in the U.S.

A diagnosis of cancer was essentially a death sentence and the general attitude of physicians toward it was one of hopeless defeat.

Although there was great need among both doctors and laymen for greater knowledge about cancer, the young Society directed its first efforts in cancer control to educating the general public. Popular literature on the subject was prepared by competent authorities and given widespread distribution. By means of newspapers, magazines and lectures, every effort was made to enlighten the public on the early signs and symptoms of cancer and the necessity for prompt and adequate treatment.

Devising methods of accomplishing the task was a difficult problem. Before the Society began its educational campaign, cancer was an extremely distaste-

VOLUNTARY HEALTH AGENCY A partnership of physicians, other health professionals, nonmedical community leaders and dedicated lay men and women from every walk of life, the voluntary health agencies have played a vital role in the betterment of public health in America for more than 50 years. It has been largely through their efforts that attention has been drawn to certain diseases that have claimed an appalling number of lives annually because of our meagre knowledge about them and our inadequacy in controlling them. These agencies have been fostered by the same public-spiritedness that has characterized most campaigns of community interest in the United States since the beginning of its history. Established at the instigation of the people and subsisting on funds provided by them, the voluntary health agencies have been effective instruments in the public welfare.

ful topic of conversation, spoken of in whispers, if at all. There was great inertia and skepticism to be overcome in both the laity and the medical profession.

The only measures which seemed to offer any hope in controlling cancer were those directed to each individual, warning him of the dangers of cancer and alerting him to obtain prompt medical attention for any symptom or condition suggestive of the disease.

In order to carry out its program, the Society needed formal professional sanction. The physician-founders of the Society were

all members of various existing medical societies (Association of Pathologists and Bacteriologists, American Gynecological Society, American Surgical Association and American Dermatological Society) which looked on the Society with favor.

In 1913 the American Medical Association unanimously endorsed the organization and resolved "That this movement deserves the cooperation of the medical profession of America and the Association heartily commends its worthy purpose." In the same year the Clinical Congress of Surgeons of North Amer-

ica also gave recognition to the new Society.

National

Despite the handicaps occasioned by World War I and a very haphazard financial status, the Society continued to make gains in its membership and in its work. Following the war years, attempts were made to establish branches of the Society in the field for the purpose of carrying on an educational campaign at the local level. A few strong branches were formed which gave the Society the necessary experience for the eventual development of a national organization.

By 1922, the Society had essentially changed from a regional to a national organization, its membership had increased considerably and its budget was expanding. In that year the Society was incorporated, which permitted more organized fund-raising and provided a framework for uniting the various branches of the Society into a closer cooperative effort.

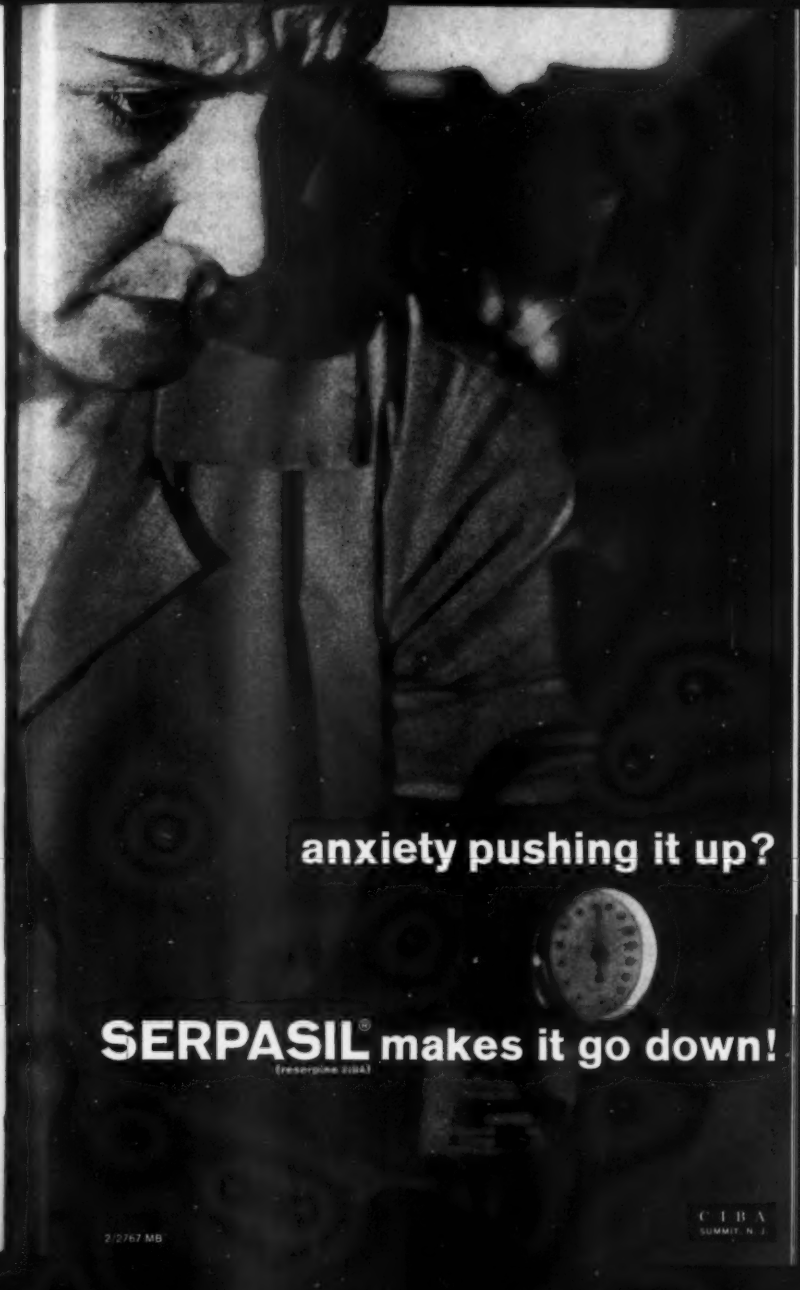
On surer footing, the Society went ahead during the twenties with its campaign for financial support, but it became evident very soon that there were not sufficient funds to do successfully

even the job of educating the public. Besides its annual drives for funds, the Society actively sought financial support from wealthy philanthropists and foundations. During this time, field representatives were added to the small national staff, and through them was established a more effective liaison between the national headquarters and workers in the community.

Facilities

As the public became enlightened about cancer and began seeking medical attention, it was soon apparent that there were not enough physicians with sufficient interest in cancer to supply the demand for diagnosis and treatment, nor were there adequate facilities available. During the period from 1929 to 1935, the Society directed its attention toward promoting the establishment of adequate facilities for taking care of the cancer problems of an aroused public and toward the education and organization of the medical profession in cancer control.

A major step forward was taken in 1929, when the American College of Surgeons, at the Society's request, set up standards and formulated plans for approving cancer hospitals, clin-



anxiety pushing it up?

SERPASIL[®] makes it go down!

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ics and diagnostic facilities.

For the purpose of instruction, entirely new educational materials, aimed at the medical profession, were prepared by outstanding physicians in cancer work. Film strips, depicting the latest diagnostic procedures and exhibits designed to stimulate the doctors' interest in cancer were widely disseminated and cancer began to take a more prominent place on the programs of county and state medical societies.

By 1935, professional education was well under way and the time seemed right for expanding the lay educational program. In considering ways of getting information about cancer into every home in America, the concept of the Women's Field Army arose. Formed under the aegis of the General Federation of Women's Clubs, the Women's Field Army was organized and became an integral part of the Society in 1936. Gaining the cooperation of numerous existing women's organizations, the Field Army set as its goal the task of disseminating the cancer message of early diagnosis and treatment, giving particular stress to cancer of the two most accessible sites in women — the breast and the uterus.

The growth and success of the

Field Army was phenomenal and it quickly became the "power plant" of the Society. Through its enormous help in the promotion of lay education as well as in fund-raising, the Society made substantial progress between 1936 and 1945 while the Field Army was in existence.

By 1944 the Society's resources had almost reached the million dollar mark, making possible even greater expansion of its activities. In this year the Society was able to undertake the support of a large-scale research program as well as a service program encompassing both professional and volunteer activities.

Thus evolved the present three-point program of research, education, and service in cancer which gave the Society new responsibilities and greater horizons. In order to accomplish these goals, the Society was completely reorganized and new by-laws and policies were instituted.

At this time the name of the Society was changed to the American Cancer Society, Inc. With continued and steadily increasing support from public contributions (which rose from \$4 million in 1945 to \$30 million dollars in 1958), the Society began to make great headway in the conquest of

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cancer. Evidence of this is the fact that more has been learned about cancer and more progress toward its control has been made in the past decade than in all previous human history.

With the reorganization of the Society in 1944, new executive leadership was obtained and a widespread marshalling of support from prominent figures in medicine, science, business and industry was begun. The Board of Directors was enlarged to provide nation-wide representation and it became established policy that the Board would be composed of equal numbers of professional and lay volunteers.

Present organization

The present Board of Directors consists of 68 members, 36 of whom are Regional Directors, while 32 are Directors-at-large. Broad policies are developed at the national level by the Board which meets three times each year. In the intervals between these meetings, an Executive Committee of 22 members of the Board exercises continuing leadership.

Decisions relating to policy and program are made by the Board on the recommendations which come to it from the various committees which it appoints

or elects. Through 60 chartered Divisions (cover 49 states and the District of Columbia) nearly 3000 county and city Units, these policies and programs are put into effect.

Committees

A flexible committee structure provides the machinery for advising the Board. These committees are made up of members of the Board as well as of many other experts in their fields, all of them volunteers. Action on the medical aspects of education, service and statistical research is recommended to the Board by the Medical and Scientific Committee which consists of all the physicians and scientists on the Board. Research allocations are proposed by the Board's Research Committee.

Other standing committees of the Board include the Nominating (Professional and Lay), Finance, Field Services, Awards, Public Information and Crusade Committees. There are also a number of standing and reference committees of the membership, including committees on Service, Education, Research, Finance and Crusade, together with such others as may be indicated from time to time. Besides providing a ready mechanism for expansion

of activities, this committee system insures representation of all interests of the membership and makes possible integration of the nationwide cancer control program.

Research activities

A budgetary allocation of 25 percent of the annual campaign funds of the Society is made to research in cancer. The Society makes grants both in the support of research and in the support of personnel for research. The grants are made by the Board of Directors, acting upon recommendations of its Research Committee. The latter Committee is counseled by a Research Advisory Council consisting of some 15 of the country's outstanding scientists and administrators. The Council is in turn advised by six advisory committees for Research on the Etiology of Cancer, Research on the Pathogenesis of Cancer, Research on the Therapy of Cancer, Institutional Research Grants, Research on Lung Cancer and Personnel for Research.

Grants in support of research are made usually to institutions rather than to individuals. Of these there are four types: Project Grants, Program Grants, Institutional Research Grants and Contracts for Research.

Grants in support of personnel for research are made either to institutions or to individuals. These grants essentially cover three different levels of scientific attainment and include post-doctoral fellowships, grants for scholars in cancer research and grants for additional faculty-level positions.

Grants are made only to institutions or individuals within the geographical limits of the United States and its territories. Research grants are awarded for any period of time, up to and including 5 years, while grants for personnel for research may be made for a longer period of time.

Each year the Society awards institutional grants to hospitals, universities and other research centers to support integrated programs coordinated by intramural cancer research committees. It also gives financial assistance in basic research to hundreds of investigators who are endeavoring to learn more about the physiology and chemistry of normal and malignant cells. It supports many scientists in clinical investigations where new cancer detection methods are being sought, where surgical and radiation techniques are being improved, and where chemotherapeutic methods are being used in order to find

BACKGROUND FOR CONFIDENCE

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Mead Johnson

Symbol of service in medicine

chemical agents effective against cancer.

Education: public and professional

For education the Society expends annually 30 percent of its total funds. A public education and information program is carried out nationally, and through divisions and units, to alert the public to cancer's danger signals and to encourage annual health examinations as well as to secure understanding of and support for the work of the Society.

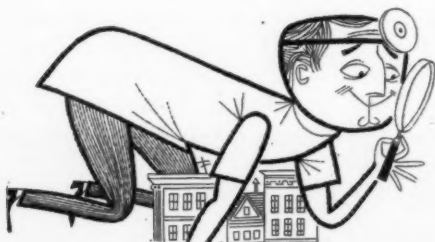
The program relies on the voluntary cooperation of many individuals and agencies, including those in the various media of communications (press, TV, radio), and of educators, public relations officials and others.

Through every means of mass communication and personal contact — through press and news

services, magazines, radio and TV, films, posters, displays, publications; through business and industry programs, club and organization activities, house-to-house visits, school and college programs; and through its own publications — the Society conducts a comprehensive information program that impresses upon the American people the importance of detecting and treating cancer in its early stages. The fund-raising operation which supports the Society's work incorporates this important educational message with its appeal.

In professional education, the primary objective is to alert physicians to the latest proven methods of diagnosis and treatment.

It is no idle philosophy that the life of the cancer patient may lie in the hands of the first physician he sees. Thus, every doctor



Did you see . . . ??

**"It Pays to
Read . . ."**

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has the responsibility of recognizing the signs of possible cancer when he is examining his patients..

With limited time and facilities, however, keeping up to date concerning clinical advances in cancer becomes a real task, especially when it is realized that cancer occurs in a relatively small proportion of any one physician's practice.

In order to place the rapidly growing knowledge about cancer at the disposal of every practicing physician, resident, intern, dentist, nurse, medical and nursing student, the Society uses all possible means of communication to reach them. In cooperation with state and county medical societies, dental and nursing associations, health departments and other health groups, the Society makes available publications, exhibits, filmed clinical teaching conferences and other professional films, refresher courses, seminars and meetings, and provides speakers and visiting specialists for cancer clinics.

Leading authorities serve as lecturers and as consultants and contributors to the Society's technical publications, monographs, films, etc., in order to insure accuracy and timeliness.

In recent years, closed circuit televised conferences have pre-

sented live demonstrations of the latest techniques in detection, diagnosis and treatment of cancer and edited versions of these programs are available as kinescopes for continuing use.

Scientific meetings

Each year the Society holds a scientific session in conjunction with its Annual Meeting. During recent years such subjects as lung cancer, radiation therapy, exfoliative cytology, uses of ACTH and cortisone in malignant diseases, uterine cancer, the role of endocrines in neoplastic diseases, cancer of the head and neck and cancer of the colon and rectum, have been critically discussed.

Every three or four years, a National Cancer Conference is sponsored jointly by the Society and the National Cancer Institute of the U.S. Public Health Service, bringing together clinicians and investigators for discussion and evaluation of the progress in the treatment of cancer.

Most of the Society's Divisions sponsor or subsidize refresher or postgraduate courses for physicians on practical aspects of cancer as the physician sees them in his practice.

The Society has a number of its own publications. It publishes

the professional journal *Cancer*, devoted specifically to basic and clinical research. It also publishes a series of monographs on cancer by site, written by authorities in the field.

Publications, library

Its publication, *CA: Bulletin of Cancer Progress*, consists of selected digests and abstracts of recent articles and other items concerning cancer which are of interest to practicing physicians.

The Society also maintains a medical library which has a comprehensive collection of books on cancer and a large number of current medical journals as well as a classified reprint collection from which pertinent reprints are available on loan to physicians. The library provides information relative to publications and authors in the cancer field and prepares bibliographies upon request for use at professional conferences or by physicians who are writing papers.

Clinical fellowship

Each year the Society allocates funds to support young physicians in advanced clinical training in cancer. On completion of their study under outstanding teachers, these doctors will take with them into their own med-

ical practice the best clinical experience with which to sharpen the community attack on cancer.

The Clinical Fellowship Program has expanded rapidly since its inception in 1948 when 20 fellowships were awarded. In the past ten years this expansion has been almost eightfold.

In addition to fellowships at the residency level, the program now provides advanced clinical fellowships for physicians beyond residency training who desire to work in the academic sphere. Greater emphasis is now being placed on this aspect of the program because of the increasing need for personnel in medical teaching. At the present time fellowships are held by physicians in 75 institutions.

Service activities

To its service program the Society currently allocates approximately 23 percent of its annual campaign funds. In general, this program is concerned with services directed toward

- 1) saving lives from cancer, and
- 2) providing comfort for cancer patients.

These activities include:

- Supporting facilities for the detection, diagnosis and treatment of cancer as well as for re-

announcing a major event
in anticoagulant therapy...

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Certified—before introduction—by 5 years of clinical experience
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new oral prothrombin depressant
control at every stage of anticoagulant therapy rapidity
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coagulant effect with vitamin K₁ preparations... rapid return to
therapeutic levels on remedication

Well tolerated and relatively nontoxic
no nausea and vomiting; proteinuria,
agranulocytosis or leukopenia yet observed
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Single daily dose convenience

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habilitation of cancer patients.

- Recruiting and training volunteers, including clinical and clerical aides, to work with professional personnel.

- Planning and implementing other services for cancer patients and their families — information service, loan and gift closets, surgical dressings, transportation, home visitor service, housekeeping service, palliative medication and supportive care of patients with advanced cancer.

The Society itself may not operate medical or laboratory facilities, nor does it actually treat cancer patients. It functions, rather, in support of the physician's effort to provide early diagnosis and adequate treatment of cancer.

The Society does not assume responsibility for the treatment of cancer patients. Its role is to assist the patient and the physician but not to interfere with the physician-patient relationship.

Payment of bills for hospitalization is disapproved in principle because it is considered not to be the most effective use of the Society's resources. It is the concern of the Society, however, that patients be directed to the appropriate agencies in the community and it therefore provides referral services for this purpose.

Clinics

The Society has had an important role in the development and maintenance of cancer clinics. In 1929 a committee of the Society undertook to investigate the medical service available in the United States and found a widespread need for cancer clinics in general hospitals.

Although a survey of available facilities was begun in 1931, it was not until 1933 that the College published the first list of 140 cancer clinics which it had approved. Progress was rapid, however, and by 1947 there were 442 such approved clinics.

At the present time there are 765 cancer clinics in the United States, its territories and in Canada which fulfill or exceed the minimal standards. The program has resulted in the formation on this continent of a network of cancer clinics in which patients can be assured of complete examination, consultative opinion, accurate diagnosis and the best treatment to be offered in the community.

The Society has long recognized the importance of tumor registries in which records of the total cancer experience within an institution or community can be kept, so that data pertaining to cancer cases are easily obtainable

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for continued evaluation of the progress in cancer control. Such repositories of information can provide important statistical and other data to guide physicians in their approach to cancer problems as well as to stimulate their interest in cancer and improve the service to cancer patients.

Many tumor registries are now in existence; 30 have already been formally accredited by the American College of Surgeons. The Society encourages the development of registries in order to maintain a continuous critical evaluation of its program.

Volunteer support

Unlike the communicable diseases, cancer has presented a particularly difficult health problem because the ultimate responsibility for its control rests essentially with each individual. No practical preventive measures on a large scale are available to public health authorities to protect people from the disease, and hence each patient has had the burden of control for himself. Education, therefore, plays a greater role in the achievement of cancer control than it does in the control of many other diseases.

The success of the Society's efforts in bringing cancer to the

attention of the public and the medical profession has been realized through a tremendous volunteer movement in which both physicians and laymen assume strategic roles.

Guiding force

Medical leadership has been essential at all levels of the Society's operation and in every aspect of its program, both as regards planning and implementation. As on the national level, it is important also at the local level that physicians advise and participate in the development of the program so as to insure medical responsibility in all undertakings.

Physicians are the guiding force in the formulation and management of programs in cancer research, education and service. As professional leaders, they are uniquely cognizant of the existing medical needs of the community, both with respect to the public and the medical profession, and hence they are the keystone of an effective cancer program.

No less important in the work of the Society, however, is the enormous contribution of lay volunteers. Participation in the activities of the Society is shared by many groups of laymen—civic organizations; service clubs; professional and fraternal groups;

business, industry and labor; farm organizations; religious, social and educational groups; and the nation's Armed Forces. They contribute the interest, experience and time of their members to promote active cancer control programs within their own organizations and communities. Without the cooperation of these men and women, the Society would cease to be effective.


Fund appeals

These groups are largely responsible for the success of the independent fund-raising and educational crusade each year. Financial support for the Society's rapid growth has been obtained through this means.

In some areas the Society has participated in Community Chests or federated appeals and in recent years continuing pressure has been placed on the Society by certain groups to further increase this participation. In a recent study of this problem, the policy makers of the Society found that financial support is

greater and accrues more rapidly when the drive is independent than when it is federated, and that the educational program is more intensive when it is a part of an independent crusade than when it is combined with many other causes in a united appeal.

Therefore, in 1955, the Society advised its units not to enter into joint fund-raising drives and requested those units already in such federated efforts to withdraw from them by 1960. Support to this decision was given on June 26, 1958 by the House of Delegates of the American Medical Association after critical deliberation of the objectives of all voluntary health agencies. They have handed down the resolution: "That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own campaigns of fund-raising and public education and to direct programs of research in their particular spheres of interest." The American Cancer Society is grateful for this endorsement of its efforts.



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QUIET, PLEASE!

YOUR WIFE'S TALKING

HOW NOT TO SPEND YOUR HOURS ALONE!

Adele S. Rubins

"Recollect that the Almighty, who gave the dog to be companion of our pleasures and our toils, hath invested him with a nature noble and incapable of deceit." — SIR WALTER SCOTT



Throughout our courtship, I was warned by members in and out (mostly out) of the medical profession that I would be continually subjected to the eternal scourge of the doctor's wife: many hours alone.

Because of this, I embarked on a succession of hobbies and interests including the usual sewing, painting, ceramics, all and sundry methods to keep the little hands occupied. Yet, though occupied, I was still alone. After three years of marriage to a medical student, intern, medical resident and a general surgery resident (all encompassed in one tired individual), I decided that a more interesting and time consuming hobby was in order. A living thing, a pet, said I . . .

And of many kinds of pets, what could be more innocuous, adorable and easy to manage than a carefree little bundle of golden cocker spaniel fur? (Answer: a herd of stampeding elephants.)

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Thus we purchased a "care-free little bundle" of you-know-what. According to all of the latest dog literature, one should pick the "happiest, healthiest and heartiest" of a litter. On viewing seven cocker-spaniels chewing each other's ears off, we chose the one who spent most of her time leaping through the air, unafraid, and between leaps, eating with great gusto. This was certainly the "heartiest" of the lot.

Upon leaving mother, brothers and sisters, this "heartiest," this nerveless trapeze artist, was immediately transformed into a shivering, whining, fearful, three pound bundle of complete dependence.

Our kitchen soon became a kennel, strewn with toys, newspaper, boxes, food and a barrier reef of suitcases piled up at the entrance. It smelled like a kennel, too. We took our meals in the living room.

**about
the
author**

Born in Montreal, Canada, the author is a graduate of Brooklyn College; she has been employed as both a medical and legal secretary and has written for various school magazines. Mrs. Rubins is married to a surgical resident and thoroughly enjoys being a doctor's wife.

Growth

Gradually, our shivering dog became an entity, a dominating canine, who promptly took over house and home and dictated our habits.

She determined our hours of sleep (11 PM to 5 AM), our eating patterns and even our decorating schemes. Disliking her kitchen, she remodeled it by removing the wallpaper, the bottom of the refrigerator, part of the linoleum, a few chair legs, and finally she wrestled the garbage pail out of her domain. Recently she has taken to barking and growling at the stove. (I don't know where else we could put it, though.)

Help wanted

We would occasionally punish her by removing her to the bathroom. Unfortunately, this nautical cocker showed a peculiar penchant for water (with the exception of her bath), and after thrice pulling her from happy immersion in the toilet bowl, we abandoned this method of discipline.

She also exhibits poor taste in her teething. My diamond engagement ring, watches, money, medical instruments and eye glasses all have been pried from her unyielding grip.

My husband has been a big help with the dog. He volunteered for night duty for the remainder of his residency. And when I complain about her rather wild behavior, he generally answers: "You wanted her, not me!" The simple truth of this retort makes it not one bit less objectionable. However, a couple of tirades, describing how he might help by a show of male discipline, gets no response.

Six months

Penny (we finally decided to name her) recently celebrated six months of existence. She is currently entering the adolescent phase of her development. She is becoming calmer, cooler and more controlled. When we move to a new apartment (we were given a rather pointed ultimatum) we sincerely feel that we will soon be the proud possessors of a transformed doggy, an amiable, affectionate little house pet.

As a friendly tip to you wives-with-many-hours-on-your-hands, consider carefully the following before embarking on dog-raising:

1. Do you have an ample sup-

ply of sedatives in your house? Or, are you the embodiment of calm, patient serenity?

In other words, when you fall flat on your face—while carrying a roast to the living room—due to some object your dog has carefully placed in your path, will you flip your — will your composure be shattered?

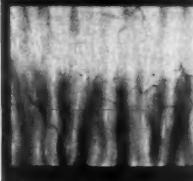
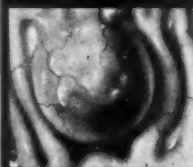
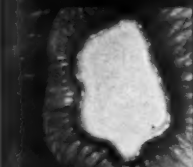
2. Do you have a home in a back yard? (That's right—in a backyard, not *with* a backyard). I have not mentioned the topic of housebreaking, but suffice it to say: a home with earth floors is a necessity.

3. Are your neighbor's children and your furniture valuable? While teething (which is an almost interminable process), your pooch will mangle everything that is not nailed to the floor—except teething toys.

Equals

To conclude, a recent article in *Time* magazine, by Dr. Leonard Lovshin of the Cleveland Clinic, states that "a puppy equals about one and a half children." My advice: Have one and a half children.

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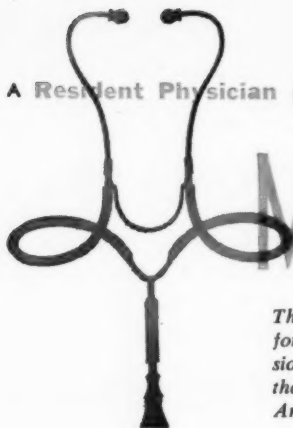
*Schneider, H.C.: *In Press, J. Intern. Coll. Surgeons*

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Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 199.

1. The diagnosis of chlorpromazine hepatitis is best made by the history plus:

- A) Auscultation of the right upper quadrant.
- B) Eosinophil count.
- C) Needle biopsy of the liver.
- D) Serum ammonia determination.
- E) Comparison of serum glutamic and oxalic transaminase.

2. Of the following, the procedure most likely to furnish a positive diagnosis of sarcoidosis is:

- A) Pleural biopsy.
- B) Gastric suction biopsy.
- C) Prescalene fat pad biopsy.
- D) Inguinal node biopsy.
- E) Pleural fluid cell block.

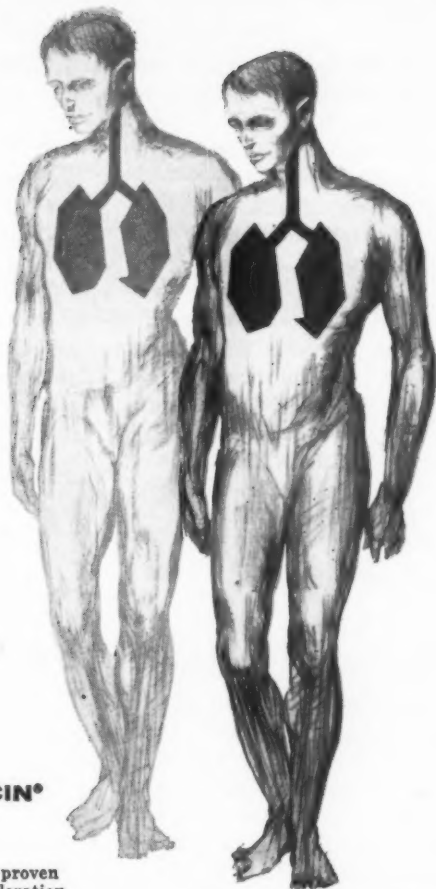
3. A syndrome characterized by blueness of the extremities aggravated by cold, edema, profuse sweating of the volar surfaces and absence of ulceration is known as:

- A) Erythromelalgia.
- B) Erythema induratum.
- C) Raynaud's disease.
- D) Livedo reticularis.
- E) Acrocyanosis.

4. A marked increase in red cell fragility suggests:

- A) Cooley's anemia.
- B) Polycythemia vera.
- C) Hand - Schüller - Christian disease.
- D) Haff disease.
- E) Congenital hemolytic anemia.

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of
difference
in
respiratory
tract
infections



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*Trademark
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5. The most common nucleated cells in normal bone marrow are:

- A) Reticulum cells.
- B) Promyelocytes.
- C) Macrophages.
- D) Megakaryocytes.
- E) Metamyelocytes.

6. A decrease in the myeloid-erythroid ratio in the bone marrow is characteristic of:

- A) A leukemoid reaction.
- B) Pernicious anemia.
- C) Gaucher's disease.
- D) Aplastic anemia.
- E) Multiple myeloma.

7. Bone marrow aspiration is of value in making a diagnosis of:

- A) Schistosomiasis.
- B) Strongyloidosis.
- C) Leishmaniasis.
- D) Clonorchis infestation.
- E) Giardiasis.

8. A reticulocyte response such as occurs when a high dose of intramuscular vitamin B₁₂ is given in pernicious anemia usually reaches its peak in:

- A) 1- 3 hours.
- B) 6-24 hours.
- C) 3-10 days.

NEWS ROUNDS

Personality Held Key to Auto Accidents

"Average" Driver Suspect—Personal attitude, not driving aptitude is emerging as the most important factor in motor vehicle accidents, according to J. J. Conger, Ph.D., head of the division of clinical psychiatry, University of Colorado Medical Center. Writing in the March issue of Medical Times, Dr. Conger states that such "traditional" measures as coordination, psychophysiological functioning and intelligence are proving of little or no value in differentiating the safe and unsafe driver. Current studies, the author indicates, show that "we drive as we live," and for "the average driver," worry about personal problems or work frustrations, anger, tension, even unusual elation, should be recognized as danger signals.

D) 7-21 days.

E) 30-90 days.

9. What the patient describes as "smoky urine" usually is:

A) Galactosuria.

B) Hematuria.

C) Hemoglobinuria.

D) Pyuria.

E) Albuminuria.

10. The incubation period of tetanus is usually:

A) 36 hours.

B) 3- 4 days.

C) 5- 7 days.

D) 8-12 days.

E) 14-20 days.

11. Section of the optic tracts on one side causes:

A) Blindness of the side opposite the lesion.

B) Binasal hemianopsia.

C) Complete homonymous hemianopsia.

D) Blindness on the side of the lesion.

E) Bitemporal hemianopsia.

12. Adie's syndrome is characterized by a:

A) Miotic pupil responding to light but not to accommodation, and hyperactive tendon reflexes.

B) Miotic pupil fixed to light, responding to accommodation.

C) Large pupil responding to

light but not to accommodation, and absent tendon reflexes.

D) Miotic pupil fixed to light and accommodation, and absence of tendon reflexes.

E) Large irregular pupil fixed to light, responding sluggishly to accommodation, and absence of tendon reflexes.

13. Eosinophilia is a characteristic feature of infestation with all of the following organisms except:

A) Clonorchis sinensis.

B) Echinococcus.

C) Endamoeba histolytica.

D) Trichinella spiralis.

E) Strongyloides stercoralis.

(Answers on page 199)

VOLUME 2 MEDIQUIZ READY

A second volume of 150 Mediquiz questions, answers and references compiled by the Professional Examination Service, Division of the American Public Health Association is now available in booklet form for \$1 per copy. The supply of booklets is limited. To be certain you get your copy, send your dollar now to: Professional Examination Service, Department 23-B, American Public Health Association, 1790 Broadway, New York City 19, New York. Please specify "Volume 2." (A few copies of Volume 1 are available at \$1 each for those who missed out on this valuable study aid.)

What's the Doctor's Name?



He was born in Cardross, Scotland, in 1896. After graduating from Dunbarton Academy, he decided to make medicine his career, and entered Glasgow University in 1914. His studies were interrupted by World War I.

He finished his studies in 1919

and in 1921 he married Agnes Mary Gibson, also a physician.

After four years of practice in South Wales and a year of study of pulmonary disabilities in the coal fields for the Ministry of Mines he moved to London. There he entered private practice in the West End. He has a D.P.H. degree from London University and is a member of the Royal College of Physicians.

In 1930, poor health forced a convalescent vacation in the West Highlands of Scotland. This gave him the opportunity he had long wanted to try to write a novel. At the end of three months the

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novel — a quarter of a million words—was finished, mailed to a publisher and accepted immediately. It was an instantaneous success, translated into five languages and favorably compared by critics with the work of Dickens, Hardy and Balzac.

From 1931 to the present he has been writing best sellers and near best sellers and is considered one of the most popular and distinguished novelists of our times. His first novel, *Hatters Castle*, was followed by *Three Loves*, *Grand Canary*, and *The Stars Look Down*.


His fifth novel *The Citadel*

published in 1937, deals with the life of a doctor as does *Shannon's Way*, published in 1948. His autobiographical *Adventures in Two Worlds* deals with his two careers, medicine and literature.

Other titles would include *The Keys Of The Kingdom*, *The Green Years* and *The Spanish Gardener*.

From 1941 to 1945 he was in the United States working for the British Ministry of Information. He has since, with his wife and family, taken up residence in the United States.

Can you name this doctor?
(See page 199).



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1. Peiser, U.: Med. Klin. **50**:1479 (Sept. 2) 1955.
2. Berndt, R.: Arzneimittel-Forsch. **5**:711 (Dec.)
1955. 3. Rostalski, M.: Zentralbl. Gynäk. **78**:1153
(July 21) 1956. 4. Holbrook, A. A.: Am. Pract. &
Digest Treat. **10**:842 (May) 1959.

VIEWBOX DIAGNOSIS

(from page 25)

CALCIFICATION OF VAS DEFERENS

Occurs occasionally in males
with longstanding diabetes.

MEDIQUIZ ANSWERS

(from page 192)

1 (C), 2 (C), 3 (E), 4 (E), 5 (E),
6 (B), 7 (C), 8 (C), 9 (B), 10 (D),
11 (C), 12 (E), 13 (C).

WHAT'S THE DOCTOR'S NAME?

(Answer from page 196)

A. J. CRONIN

RESIDENT RELAXER

(puzzle on page 33)



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